Acceptable
POC #4

Division of Health Care Facilities

PRINTED: 01/25/2016
FORM APPROVED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | TN6101 | A. BUILDING: _____ B. WING _____ | 01/15/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BROOKEWOOD NURSING CENTER, INC | 332 RIVER ROAD DECATUR, TN 37322 |

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| N 000 | Initial Comments<br><br>Based on an annual Licensure survey conducted 1/10/16 through 1/15/16 the facility was cited a Type "A" penalty for failure to ensure family notification of changes in condition, failure to implement interventions to prevent and treat Pressure Ulcers, failure to revise care plans for falls interventions and for pressure ulcers, failure to investigate injuries, and failure to prevent falls resulting in significant injury. The facility's failure placed seven residents (#23, #24, #26, #34, #40, #76, and #77) in an environment which was detrimental to their health, safety and welfare. | N 000 | This plan of correction is our credible Allegation of compliance. "Preparation and or execution of correction does not constitute admission of agreement by the Provider of the truth of the facts alleged or deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law." | 3-17-16 |
| N 401 | 1200-8-6-.04(1) Administration<br><br>(1) The nursing home shall have a full-time (working at least 32 hours per week) administrator licensed in Tennessee, who shall not function as the director of nursing. Any change of administrators shall be reported in writing to the department within fifteen (15) days. The administrator shall designate in writing an individual to act in his/her absence in order to provide the nursing home with administrative direction at all times. The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents.<br><br>This Rule is not met as evidenced by:<br>Based on facility policy review, review of facility documentaion, medical record review, observation, and interview, the facility failed to be administered in a manner to ensure notification to | N 401 | N401 1200-8-6-.04(1) Administration<br><br>1.1/15/2016-Administrator directed Emergency Meeting attended by members of the QA Committee regarding survey outcomes and resident safety, including Pressure Ulcers, Treatments not performed as ordered, Falls, and Incidents of Unknown Origin. Quality Assurance committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Business Office Manager, Activity Director, | 3-17-16 |

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| N 424 | 1200-8-6-.04(15) Administration<br><br>(15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury. | N 424 | **Attachment #1, 30**<br><br>1/20/2016 & 1/29/2016- Administrator held QA Committee Meeting where the | |

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| N 424 | 1200-8-6-.04(15) Administration<br><br>(15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury. | N 424 | Ftag 225/ N615: Incident reports are reviewed by the Director of Nursing to determine any injury | |

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| N 424 | 1200-8-6-.04(15) Administration<br><br>(15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury. | N 424 | | |

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| N 424 | 1200-8-6-.04(15) Administration<br><br>(15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury. | N 424 | 3. 01/14/2016-1/26/2016 IN-SERVICES of ALL NURSES were: Falls/ Fall Prevention, Post Falls Skill Checks, Comprehensive Care Plans, Documentation, | |

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| N 401 | Continued From page 1<br><br>family of changes in condition, to provide wound care and treatements as ordered by the physician, to investigate injuries, to ensure revision of care plans were done with appropriate and individualized interventions to prevent falls and to prevent and treat pressure ulcers, and to ensure an appropriate falls intervention program was implemented to prevent residents from having multiple falls and injuries with falls. The facility's failure placed seven residents (#23, #24, #26, #34, #40, #76, and #77) in an environment detrimental to their health, safety, and welfare.<br><br>The findings included:<br><br>Interview with the Administrator on 1/15/15 at 1:30 PM, in the Administrator's office, revealed she assumed the Administrator role at the facility in August 2015; reconvened the performance improvement meetings, and began to identify areas of concern. Further interview confirmed the Medical Director had been informed of the performance improvement meetings, they were held on Wednesdays when he was in the facility, and she thought he "may have attended one of the four meetings...not sure..." Interview continued and, when asked how facility-wide problems were being identified and addressed, the Administrator did not answer the specific question but responded, "It is going to take time..."<br><br>Refer to N-424, N-601, N-615, N-662, and N-688 | N 401 | All fall and pressure ulcer care plans will be reviewed at the time of the incident and updated during the morning clinical meeting. The MDS nurse will immediately update the case plans with appropriate intervention(s). The DON or if DON not available the nurse in attendance will counter sign to ensure interventions were added. This process of having two nurse signatures will continue with each fall and pressure ulcer care plan until the Administrator/DON is satisfied that no interventions are being missed or are inappropriate. This process will begin 1/27/2016.<br><br>Medical Director will attend monthly QA Meetings effective 1/20/2016. If the Medical Director is unable to attend a scheduled QA Meeting, the Medical Director will be consulted to select alternative date for the QA Meeting that same month. If the Medical Director fails to attend QA meetings, or assist in the planning or implementation of measures to correct identified problems at the facility, the Administrator will notify the Corporate Office for their assistance with correcting | |
| N 424 | 1200-8-6-.04(15) Administration<br><br>(15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury. | N 424 | | |

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| N 401 | Continued From page 1<br><br>family of changes in condition, to provide wound care and treatements as ordered by the physician, to investigate injuries, to ensure revision of care plans were done with appropriate and individualized interventions to prevent falls and to prevent and treat pressure ulcers, and to ensure an appropriate falls intervention program was implemented to prevent residents from having multiple falls and injuries with falls. The facility's failure placed seven residents (#23, #24, #26, #34, #40, #76, and #77) in an environment detrimental to their health, safety, and welfare.<br><br>The findings included:<br><br>Interview with the Administrator on 1/15/15 at 1:30 PM, in the Administrator's office, revealed she assumed the Administrator role at the facility in August 2015; reconvened the performance improvement meetings, and began to identify areas of concern. Further interview confirmed the Medical Director had been informed of the performance improvement meetings, they were held on Wednesdays when he was in the facility, and she thought he "may have attended one of the four meetings...not sure..." Interview continued and, when asked how facility-wide problems were being identified and addressed, the Administrator did not answer the specific question but responded, "It is going to take time..."<br><br>Refer to N-424, N-601, N-615, N-682, and N-688 | N 401 | the lack of participation. The Corporate Office will work directly with the Medical Director to meet all requirements or take measures to find a Medical Director that will.<br><br>Weekly QA Report to be sent to Medical Director by Administrator effective 1/29/2016 that will include all tags addressed in the plan of correction in addition to any other change of care issues.<br><br>Quarterly QA Report updated on3/11/2016 addressing each cited deficiency on to be used on next scheduled QA Meeting<br><br>**Attachment #14, #31** | |
| N 424 | 1200-8-6-.04(15) Administration<br><br>(15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury. | N 424 | | |

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| N 401 | Continued From page 1<br><br>family of changes in condition, to provide wound care and treatements as ordered by the physician, to investigate injuries, to ensure revision of care plans were done with appropriate and individualized interventions to prevent falls and to prevent and treat pressure ulcers, and to ensure an appropriate falls intervention program was implemented to prevent residents from having multiple falls and injuries with falls. The facility's failure placed seven residents (#23, #24, #26, #34, #40, #76, and #77) in an environment detrimental to their health, safety, and welfare.<br><br>The findings included:<br><br>Interview with the Administrator on 1/15/15 at 1:30 PM, in the Administrator's office, revealed she assumed the Administrator role at the facility in August 2015; reconvened the performance improvement meetings, and began to identify areas of concern. Further interview confirmed the Medical Director had been informed of the performance improvement meetings, they were held on Wednesdays when he was in the facility, and she thought he "may have attended one of the four meetings...not sure..." Interview continued and, when asked how facility-wide problems were being identified and addressed, the Administrator did not answer the specific question but responded, "It is going to take time..."<br><br>Refer to N-424, N-601, N-615, N-682, and N-688 | N 401 | 4. QA Committee meetings to be held weekly effective 1/29/2016 for at least 4 weeks then monthly x 3 months then at a minimum quarterly.<br><br>The QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, MDS Coordinator, Business Office Manager, Dietary Manager, Housekeeping Supervisor, Maintenance Director, Therapy Manager and Medical Director.<br><br>Corporate Nurse will be in facility weekly for four weeks and then monthly for 3 months. | |
| N 424 | 1200-8-6-.04(15) Administration<br><br>(15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury. | N 424 | | |

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| N 401 | Continued From page 1<br><br>family of changes in condition, to provide wound care and treatements as ordered by the physician, to investigate injuries, to ensure revision of care plans were done with appropriate and individualized interventions to prevent falls and to prevent and treat pressure ulcers, and to ensure an appropriate falls intervention program was implemented to prevent residents from having multiple falls and injuries with falls. The facility's failure placed seven residents (#23, #24, #26, #34, #40, #76, and #77) in an environment detrimental to their health, safety, and welfare.<br><br>The findings included:<br><br>Interview with the Administrator on 1/15/16 at 1:30 PM, in the Administrator's office, revealed she assumed the Administrator role at the facility in August 2015, reconvened the performance improvement meetings, and began to identify areas of concern. Further interview confirmed the Medical Director had been informed of the performance improvement meetings, they were held on Wednesdays when he was in the facility, and she thought he "may have attended one of the four meetings...not sure..." Interview continued and, when asked how facility-wide problems were being identified and addressed, the Administrator did not answer the specific question but responded, "It is going to take time..."<br><br>Refer to N-424, N-601, N-615, N-682, and N-688 | N 401 | | |
| N 424 | 1200-8-6-.04(15) Administration<br><br>(15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury. | N 424 | 1200-8-6-.04(15) Administration<br><br>1. Resident # 24 on 1/14/16 a care plan conference was held to | 3-17-16 |

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| N 424 | Continued From page 2<br><br>This Rule is not met as evidenced by:<br>Based on facility policy review, medical record review, facility documentation review, review of facility Incident/Accident Reports, review of Root Cause Analysis (RCA) investigations, observations, and interview, the facility failed to implement an effective fall prevention program for 4 residents (#24, #26, #23, #40) of 8 residents reviewed for falls of 20 residents with multiple falls. The facility's failure to implement new interventions and have an effective fall prevention program resulted in injuries for all four residents and placed resident #24, #23, #26, and #40 in an environment detrimental to their health, safety, and welfare. The systematic failure to ensure any resident at risk for falls was provided effective interventions, failure to ensure alarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place any resident at risk for falls in an environment detrimental to their health, safety, and welfare.<br><br>The findings included:<br><br>Review of facility policy, Falls, Post-Falls Protocol, dated 8/2012, revealed "1...c. When a resident is found on the floor, the most logical conclusion is that a fall has occurred. The facility is obligated to investigate and try to determine how he/she got there, and to put into place an intervention to prevent this from happening again...c. Take a full set of vital signs; check blood sugar, if resident is diabetic,...e. Interview the resident and any witnesses for the fall to determine the exact circumstances and cause of | N 424 | review and correct care plan to individualize and meet the need of resident, to reduce frequency of falls, and to prevent injury. Interventions not appropriate or repetitive were removed and interventions more suitable for resident added to prevent reoccurrence of falls and prevent injury if fall occurs. Resident fall risk was reviewed by Director of Nursing on 1/17/16 and continues to be high risk (score "20").<br>The falls tracking log was updated by the Director of Nursing on 1/17/16.<br><br>Resident # 24 was discharged from facility on 1/24/16<br><br>Resident #26: on 1/19/16 a care plan conference was held to review and correct care plan to individualize and meet the need of resident and to reduce frequency of falls and to | |

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| N 424 | Continued From page 3<br>the fall...g. Document the fall in the resident's chart and on the 24 Hour Report...i. Fill out and follow through with an Incident Report...5. The incident report and nurse's notes must include the following information...h. Time the family was notified. i. The time the physician was notified. j. New fall intervention implemented to prevent reoccurrence of falls...7. The interdisciplinary care team will discuss the resident's fall at the next day's Morning Report, and will determine at least one new intervention for the resident's fall risk care plan. 8. The MDS [Minimum Data Set] Coordinator or Director of Nursing [DON] will...a. Enter the fall in the Falls Log with its time, date, and location. b. Complete a falls risk assessment. c. Add new interventions to the resident's fall risk care plan. d. Inform the Charge Nurse of the new interventions...10. The Director of Nursing or designee will maintain and update the Falls Log for every resident who falls. a. Each resident will have a separate Falls Log to record the number of falls the resident has had, and track for patterns. b...Information on each resident's page includes...iii. New interventions implemented after the fall."<br><br>Review of the facility policy, Falls-Clinical Protocol, undated, revealed "...Monitoring and Follow-Up...2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling...4. If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions..."<br><br>Medical record review revealed Resident #24 was | N 424 | prevent injury. Interventions not appropriate or repetitive interventions were removed and interventions more individualized to resident were added to prevent reoccurrence of fall and prevent injury. The falls tracking log was updated by Director of Nursing on 1/17/16.<br><br>Resident was discharged from facility on 2/26/2016.<br><br>Resident # 23: Resident care plan was updated by MDS Coordinator 1/27/16. Care plan was individualized to reflect more appropriate interventions and to eliminate repetitive interventions. Pressure pad alarm was added on 1/22/16. Resident was discharged on 2/16/2016.<br><br>Resident # 40: Care plan was reviewed by MDS and treatment nurse on 1/27/16 | |

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| N 424 | Continued From page 4<br>admitted to the facility 8/20/10, with diagnoses including Alcoholic Cirrhosis of Liver, Chronic Airway Obstruction, Dementia with Behavioral Disturbances, Depressive Disorder, Diabetes Mellitus, and Chronic Persistent Hepatitis; and re-admitted 7/10/15 with diagnoses including Aftercare for Healing Traumatic Fracture of Hip, and Difficulty Walking.<br><br>Review of facility documentation revealed Resident #24 had 48 falls between 1/31/15 and 1/5/16, 32 of which had no new interventions to prevent falls. Of the 48 falls, 9 required emergency room visits, and 4 resulted in traumatic injury.<br><br>Review of a facility Incident/Accident Report dated 1/31/15, revealed, "Resident turning to transfer self from w/c to bed with no assistance and fell into floor beside bed. No apparent injuries, denies pain...Additional comments and/or steps taken to prevent recurrence: Instructed to call for help o [with] transfers..."<br><br>Review of the facility's RCA (undated) for the fall on 1/31/15, revealed, "Resident fell when transferring self from w/c to bed. No injuries noted. Action Plan: Instructed to call for help with transfers..."<br><br>Review of the Care Plan dated 12/26/14 revealed, "Be sure the resident's call light is in reach and encourage to use it for assistance as needed..." This intervention had an effective date of 12/26/14, and was in effect prior to the fall. No new interventions were implemented.<br><br>Review of a facility Incident/Accident Report dated 2/8/15 revealed, "Resident [#24] in bathroom trying to stand and pee [urinate] when | N 424 | and all inappropriate interventions removed and more individualized interventions added. Resident fall risk reviewed by Director of Nursing on 1/17/16 and resident continues to be high risk for falls. Resident tracking log was updated on 1/17/16 by Director of Nursing to reflect falls.<br>Resident # 40 was discharged on 2/22/2016.<br>2. All Residents have the potential to be affected by the cited deficiency.<br><br>All resident charts were reviewed on 1/16 by Director of Nursing and Assistant Director of Nursing for fall risk scores. 3 charts were found to have scores that were added incorrect. These scores did not change the level of risk for falls and were corrected. The corporate nurse also reviewed all charts on 1/22/16 and none were found to be inaccurate. | |

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| N 424 | Continued From page 5<br>fell in front of commode. Abrasion noted to left lower back...Additional comments and/or steps taken to prevent recurrence: Encourage to call for assistance. Instructed to sit and pee..."<br><br>Review of the facility's RCA (undated) for fall 2/8/15 revealed, "Resident was in the BR [bathroom], fell while using the BR...Action Plan: Enc. [encourage] to call for assistance, Instructed to sit on commode..."<br><br>Review of the Care Plan dated 12/26/14 revealed, "Be sure the resident's call light is in reach and encourage to use it for assistance as needed..." This intervention had an effective date of 12/26/14, and was already in effect. Continued review revealed the Care Plan had not been revised to include "Sit on the commode." No new interventions were implemented.<br><br>Review of a facility RCA (undated) for a fall on 2/15/15 revealed, "Resident reported that he had fallen on Sunday night after questioning a lg [large] bruise to L [left] lower back...Action Plan: Enc. res. [resident] to use call light and ask for assistance..." This intervention had an effective date of 12/26/14, and was in effect prior to the fall. No new interventions were implemented.<br><br>There was no Incident/Accident Report available for review for the fall on 2/15/15.<br><br>Review of the Incident/Accident Report dated 2/19/15 revealed, "Resident observed by staff on the floor near bed. Staff had seen res sitting in w/c 10 mins [minutes] prior...Additional comments and/or steps taken to prevent recurrence: Use call light for assistance..."<br><br>Review of the RCA (undated) for the fall on | N 424 | All care plans of those residents who were at risk for falls were reviewed by the MDS Coordinator on 1/28/2016 and found that there were no residents "at risk for falls" that did not have a fall risk.<br>All charts of the residents at risk for falls were reviewed by both MDS corporate nurse and Director of Nursing and inappropriate interventions and repetitive interventions removed. All care plans are current with individualized interventions.<br>On 1/22/16 In-service was conducted on log rolling by therapy and continued daily by therapy/Assistant Director of Nursing and until all nursing staff had been educated.<br>**Attachment #15**<br><br>Beginning 1/14/16 In-services of all nurses were conducted by Director of Nursing/Assistant | |

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| N 424 | Continued From page 6<br><br>2/19/15 revealed, "Res. had been observed by CNAs [certified nurse aide] sitting in w/c while making rounds. Staff notified CN [charge nurse] Pt [patient] was observed 10 mins later lying on the floor near his bed. Action Plan: Eric, to call for assistance. Eval [evaluate] for move closer to N.S. [nurses station]..."<br><br>Review of the Care Plan revised 2/19/15 revealed, "Eval [evaluate] for room change closer to N.S. [nurses station]."<br><br>Review of the facility documentation (Incident/Accident Reports) revealed the resident had a room change between 6/14/15 and 6/30/15, the exact date is unknown. Continued review revealed the resident remained in the same location for approximately 130 days before changing rooms.<br><br>Review of a facility Incident/Accident Report dated 3/10/15 revealed, "Resident stated I got out of w/c and fell forward on to a mat that was on the floor for the other resident's low bed. Additional comments and/or steps taken to prevent recurrance: Reinforce resident on safety precautions..."<br><br>Review of a facility RCA (undated) for the fall on 3/10/15 revealed, "Res. reported he got out of w/c and fell forward on to mat beside roommate's bed. Action Plan: Instructed on safety precautions..."<br><br>Review of the Care Plan dated 12/26/14 revealed the Care Plan had not been revised after the fall on 3/10/15 to include identifying safety precautions.<br><br>Review of a facility Incident/Accident Report | N 424 | Director of Nursing /Administrator on the following: Falls, post falls, comprehensive care plan documentation.<br>These in-services continued until all nursing staff in facility had been in serviced. The last nurse returned from leave on 2/22/16 and received the in service training by the Assistant Director of Nursing prior to taking her assignment.<br>**Attachment #16**<br><br>On 1/26/16 An Alarm Check Log was started by the DON. All nurses and CNAs were in serviced on proper way to complete form and actions to be taken if any malfunction exists.<br>**Attachment # 19**<br><br>An Intervention Log was started by Director of nursing on 1/26/2016 to ensure nurses were able to determine at a | |

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| N 424 | Continued From page 7<br>dated 3/12/15 revealed, "...Someone yelled resident was in floor, went to room & [and] found resident sitting in floor. He stated he had slid out of chair,..level of consciousness alert with some confusion.... Additional comments and/or steps taken to prevent recurrence: Turn light on for assistance when needing help c [with] something he wants to get in room..."<br><br>Review of the RCA (undated) for the fall 3/12/15 revealed, "Admission Coordinator called for assistance-res. in the floor. Res. stated he slid out of his chair....Action Plan: Res. instruction.<br><br>"Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed," was in effect 12/26/14, and no new interventions were implemented.<br><br>Review of an Incident/Accident Report dated 3/23/15 revealed, "Sitting on the side of his bed reaching for his urinal that he placed on the floor at the head of his bed in the process he slipped to his knee...Additional comments and/or steps taken to prevent recurrence: Suggested resident keep urinal within easy reach of call for assistance..."<br><br>Review of the RCA (undated) for the fall 3/23/15 revealed, " Res. reported he was sitting on his bed and reached down to get his urinal and slid off the bed to his knee....Action Plan: Resident advised to keep urinal within easy reach..."<br><br>Review of the Care Plan revised 3/23/15 revealed, "Res. to keep urinal in easy reach."<br><br>Review of the Incident/Accident Report dated 4/4/15 revealed, "Resident found in floor of room. When asked what happened, stated fell into wall, | N 424 | glance what interventions were in place to assist in addressing fall risks for Residents. An in-service was conducted by the Director of Nursing and Assistant Director of Nursing on 1/26/2016. This Intervention Log is updated daily in the daily clinical meeting by Interdisciplinary Team.<br>The Interdisciplinary Team consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services and Therapy Manager.<br>**Attachment # 20**<br><br>Nurse management team was in serviced on MDS , care plans, alarm logs, and fall analysis by The Corporate MDS nurse on 1/29/16.<br><br>The Nurse management Team is comprised of the Director of Nursing, Assistant Director of Nursing and MDS coordinator.<br>**Attachment #21** | |

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| N 424 | Continued From page 8<br>fell backwards into bed, then hit air conditioner before hitting floor...Additional comments and/or steps taken to prevent recurrence: Resident sent to ER [emergency room] for eval and tx [treat]..."<br><br>Review of facility RCA dated 7/7/15 (93 days after the fall) for the fall on 4/4/15, revealed, "Res. on the floor in room. Res. stated he fell into the wall, then into bed, then hit A/C [air conditioner] unit before falling to the floor...Action Plan: ABT [antibiotic] for UTI [urinary tract infection]. Res. enc to get assist for transfers..."<br><br>Review of the Care Plan revised 4/4/15 revealed "To ER for Eval ABT for UTI.<br><br>Review of a facility Incident/Accident Report dated 4/11/15 revealed, "...Resident fell into floor backwards, lost balance found by CNAs...Additional comments and/or steps taken to prevent recurrence: Neuro [neurological] checks, instructed to call for assistance..."<br><br>Review of the RCA dated 7/7/15 (86 days after the fall) for fall on 4/11/2015 revealed, "Res. was standing up in his room, Res. lost balance, fell to floor. Staff member was in the next room, heard fall & [and] went to check on res...Action Plan: Neuro checks. Res instruction..."<br><br>"...Be sure the resident's call light is in reach and encourage to use it for assistance as needed..." had an effective date of 12/26/14, and was in effect prior to the fall. No new interventions were implemented.<br><br>Review of the facility Incident/Accident Report dated 4/13/15 revealed, "Resident came up the hallway & stated that he had fallen, large skin tear on mid-arm...Additional comments and/or steps | N 424 | As of 3/10/16 there were only 4 residents remaining in building.<br><br>3. All residents' charts with falls are reviewed daily by the interdisciplinary team for minimum of 3 days to ensure interventions are appropriate for each fall. The intervention log and care plan interventions are also reviewed with the charts to ensure they are compatible and to determine if interventions need to be readdressed. Falls Risk Assessments will be reviewed at the clinical meeting by the Interdisciplinary Team and updated as necessary. During daily clinical meetings the Director of Nursing along with the Interdisciplinary Team will discuss root causes of the fall and determine the root cause. Steps will be taken to update care plan intervention at that time to prevent fall from | |

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| N 424 | Continued From page 9<br>taken to prevent recurrence: Stay out from under beds where he has supply of fruit and candies..."<br><br>Review of the RCA dated 7/7/15 (84 days after the fall) for the fall on 4/13/15, revealed, "Res. wheeled up hallway in w/c and stated he had fallen in his room. S.T. [skin tear] to R arm. Res. reported to DON 4/14/15 he tripped while going through his shoes...Action Plan: Res. instruction..."<br>This intervention had an effective date of 12/26/14. No new interventions had been implemented after the fall on 4/13/15.<br><br>Review of a facility Incident/Accident Report dated 4/22/15 revealed "...Res [Resident #24] seen w/c coming down hallway. Holding rag to forehead above right eye...Additional comments and/or steps taken to prevent recurrence: Use call light for assist - transfers. Keep area free of clutter..."<br><br>Review of the RCA dated 7/7/2015 (75 days after the fall) for the fall 4/22/15 revealed, "Res. came down hallway in his w/c with a rag to forehead above right eye. Res. reported he got up out of w/c & fell forward and hit head on chest of drawers...Action Plan: Res. instruction keep area free of clutter..."<br><br>Review of the Care Plan revealed the intervention "Keep resident area free of clutter..." was already in effect at the time of the fall with an effective date of 12/26/14. No new interventions were implemented after the fall on 4/22/15.<br><br>Review of a facility RCA dated 7/7/15 (67 days after the fall) for the fall dated 4/30/15 revealed, "Res. observed sitting on the floor in front of w/c. Res. states he was trying to get into w/c and | N 424 | happening again or reduce chance of injury on each fall.<br>The incident report will be reviewed during daily clinical meeting headed by the Director of Nursing with the Interdisciplinary Team input.<br>The team will address the root cause of the fall and determine a probable root cause of the fall. Once Root Cause Analysis has been determined the Interdisciplinary Team will sign the Root Cause Analysis form and will be maintained in Resident fall log by Director Of Nursing.<br>Alarm check log will continue to be checked q 2hours by CNAs on all residents with Alarms (there are currently (0) at this time.<br>The Alarm check log is signed by the CNA at the end of their shift and given to the charge nurse at the end of the day when completed. These logs will be turned in to the Director of | |

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| N 424 | Continued From page 10<br>fell...Action Plan: Instructed to use call light..."<br><br>There was no Incident/Accident Report dated 4/30/15 available for review.<br><br>Review of a facility Incident/Accident Report dated 5/14/15 revealed, "Resident found sitting on floor between his bed & w/c...He was transferring himself and missed the w/c. Abrasion noted on lower back. No first-aid needed...Additional comments and/or steps taken to prevent recurrence: Resident is non-compliant but reminded him to call for assistance when transferring from bed to w/c..."<br><br>Review of the RCA dated 7/7/15 (53 days after the fall) for the fall dated 5/14/15 revealed, "Resident room, unassisted transfer. Found sitting on floor in room. Stated transferring self and missed wheelchair. Resident non compliant, Poor safety awareness...Action Plan: Resident reminded to call for help..." This intervention had an effective date of 12/26/14, and was in effect prior to the fall. No new interventions were implemented after the fall on 5/14/15.<br><br>Review of a facility Incident/Accident Report dated 5/20/15 revealed, "Resident was coming out of the B/R [bathroom] and fell in floor...c/o [complained of] lower back pain...Additional comments and/or steps taken to prevent recurrence: Encouraged to call for assistance..."<br><br>Review of the RCA dated 7/7/15 (47 days after the fall) for the fall on 5/20/15 revealed, "Resident took self to bathroom unassisted. Fell after using bathroom. Poor safety awareness. Refuses to call for assistance...Action Plan: Reinforce need to call for assistance..." | N 424 | Nursing during normal duty days and on 1st day of regularly scheduled work day. The Director of Nursing will review for accurateness of log and investigate any discrepancies The intervention log started on 1/26/16 is being continued to be checked by all nurses on all residents with falls q shift. The resident intervention log is signed off at the end of their shift and given to Director of Nursing by charge nurse in am for review for possible changes to interventions during morning clinical meeting.<br>On each fall the incident report will be reviewed during daily clinical meeting headed by the Director of Nursing with the Interdisciplinary Team input.<br><br>**Attachment# 19**<br><br>Incident reports for fall will be reviewed for accuracy and completion as per Fall Policy. The team will address the root | |

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| N 424 | Continued From page 11<br><br>Review of the individualized Fall Log for Resident #24 revealed no documentation for the falls occurring during the month of May 2015.<br><br>Review of a facility Incident/Accident Report dated 6/14/15 revealed, "...Resident in bed-1 hollering for help also placed on call light. Stated he [roommate] did not see but heard resident [#24] asking for help. Resident #24 was found lying on Lt [left] side propped on Lt elbow with 1" [inch] laceration to Lt brow also c/o Lt hip hurting and Rt [right] hip hurting stating Lt was worse...Resident was placed on sheet with four staff members moving from floor onto bed carefully holding body to move in unity pt. [patient] c/o pain Bil. [bilateral] hips. Pressure bandage to Lt brow...Additional comments and/or steps taken to prevent recurrence: Resident reminded to place on call light for help from staff and also instructed not to take off body alarm when staff leaves his presence..." Continued review revealed Resident #24 was taken to the ER for evaluation and treatment of injuries.<br><br>Medical record review of the Physician Documentation electronic charting from the hospital revealed resident presented to ER with "complaints of fall injury...complains of pain all over...pain in his hips, elbows, and a lac [laceration] above his left eye. Reportedly he sustained another fall last week...Musculoskeletal/extremity: bilat [bilateral - both sides] with abrasions and tenderness...Skin: Scattered abrasions and contusions...Laceration: Wound Repair of 3 cm [centimeter, 1.2 inch] subcutaneous laceration to face/left forehead...Skin closed with a thin layer of adhesive...Discharged to Home. Impression: Hepatic Encephalopathy, Cirrhosis, Closed Head Trauma, Forehead Laceration, Cervical Sprain. | N 424 | cause of the fall and determine a probable root cause of the fall. The team will recommend any changes needed to address the appropriate interventions for reduction of reoccurring falls and eliminate injury if falls reoccur.<br>In addition to the incident report, The 24 hour report along with the physician's orders will be brought to the clinical meeting to ensure falls were addressed by the nurse on shift and interventions were documented.<br>After each fall therapy will perform a fall screen within 24 hours of notification and recommendations will be brought to clinical meeting by therapy and discussed for implementation.<br>The charge nurse on A-Hall is responsible to ensure all monitoring forms, incident report and other data required | |

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| N 424 | Continued From page 12<br>Condition is Stable..."<br><br>Review of the RCA dated 7/7/15 (22 days after the fall) for the fall on 6/14/15 revealed, "Unassisted transfer. Resident fell transferring from chair to bed. Poor safety awareness...Action Plan: Remind resident to call staff for assistance. Instructed resident on alarm being for safety. Do not remove or turn off..."<br><br>Review of the Care Plan dated 12/26/14, and the Incident/Accident Reports, and RCA's from 1/31/15 - 6/14/15, revealed the resident was to have a bed alarm in place effective 12/26/14. Further review revealed this was the first fall the facility addressed the placement of the alarm or whether it was functioning at the time of the fall. Continued review revealed the facility revised the Care Plan on 6/14/15, to include "Reminded resident not to turn off alarm."<br><br>Review of the Fall Risk assessment dated 6/22/15 revealed Resident #24 scored 21 indicating the resident was high risk for falls (Total score of 10 or above represents high risk).<br><br>Review of a facility Incident/Accident Report dated 6/22/15 revealed, "3rd shift CNA...heard res yelling for help, she went in his room. Found res on floor @ [at] the foot of his bed. S/T [skin tear] to R forearm...Additional comments and/or steps taken to prevent recurrence: Encouraged res to use call light for assistance & use appropriate footwear to keep from slipping..."<br><br>Review of the RCA dated 7/7/15 (14 days after the fall) for the fall on 6/22/15 revealed, "Self transfer, ambulation in room without assistance. Resident states he was up getting some items and fell...Action Plan: Encourage resident to call | N 424 | is placed in the Director of Nursing box for the next clinical meeting.<br><br>During off hours and weekends regardless of shift any incident resulting in injury, abuse or suspected abuse, or injury of unknown origin will be called to the Director of Nursing and/or Administrator for immediate action. Incidents that are serious in nature requiring a visit to ER will be immediately called to the MD for orders to transport. Nurses are instructed in case DON/Administrator/MD can not be reached to initiate 911 call then continue to try to contact above. Incident reports not resulting in actual harm will be completed and turned in to the Director of Nursing during next scheduled clinical meeting. All nurses in serviced on the fall | |

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| N 424 | Continued From page 13<br>for assistance. Use appropriate footwear to prevent slipping..."<br><br>Review of the Care Plan revealed, "...Be sure the resident's call light is in reach and encourage to use it for assistance as needed...Non-skid footwear at all times..." had effective dates of 12/26/14, and were in effect prior to the fall. No new interventions were implemented after the fall on 6/22/15.<br><br>Review of a facility Incident/Accident Report dated 6/27/15 revealed, "...Resident found lying in floor on left side. Laceration on L [left] eye brow, ST [skin tear] on L elbow. c/o pain left arm. Sent to ER [emergency room]...Additional comments and/or steps taken to prevent recurrence: Use call light for assist..."<br><br>Medical record review of the Physician Documentation electronic charting from the ER dated 6/28/15 revealed Resident #24 presented to the ER with "...complaints of Fall Injury...pt has frequent falls...sent from...Nursing Center for fall, found on floor lying on left side with orbital laceration and left elbow pain and skin tear. Pt well known to me from prior visit...Laceration: Wound repair of 4 cm [1.6 in] partial thickness laceration to left temple and left eye...Skin closed with 3 4.0 Prolene [suture material] using Simple sutures...Disposition: 6/28/15...Discharged to Nursing Home. Impression: Facial Laceration, Elbow Contusion, Abrasion..."<br><br>Review of the RCA dated 7/7/15 (10 days after the fall) for the fall on 6/27/15, revealed, "Unassisted transfer. Staff found resident on floor after attempting to transfer self. Poor judgement. Poor safety awareness...Action Plan: Use call light for assist..." Continued review of | N 424 | procedure and posted at Nurses Station.<br>**Attachment# 5,16**<br><br>All incident reports will be faxed to the Medical Director. Incidents with serious injury will be called to the Medical Director; Original Incident Reports will continue to be placed in the Medical Directors Notebook for review and signature on his weekly visit to the facility.<br><br>4. QA Committee meetings to be held weekly effective 1/29/2016 for at least 4 weeks then monthly x 3 months then at a minimum quarterly.<br><br>The QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, MDS Coordinator, Business Office Manager, Dietary Manager, Housekeeping Supervisor, | |

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| N 424 | Continued From page 14<br><br>the RCA revealed the facility identified Resident #24 had poor judgment and poor safety awareness, but did not put any new falls interventions in place for a resident with poor judgment and poor safety awareness. The facility continued to utilize an action plan of "use call light for assist" with a resident who had already had 16 falls.<br><br>Review of a facility Incident/Accident Report dated 6/30/15 revealed, "...Resident came out of his room for smoke break told a CNA that he had fallen in his room. No witnesses- no new injuries... Additional comments and/or steps taken to prevent recurrence: Tried to cont [continue] reinforce staying in w/c & asking for help - resident refuses to comply to this request..."<br><br>Review of the facility's RCA dated 7/7/15 (8 days after the fall) for the fall on 6/30/15 revealed, "Resident stated fell getting into w/c - not witnessed. Resident going to smoke, blood noted on elbow. Resident states fell when getting into w/c - Poor safety awareness, failure to call for assistance. Action Plan: Reinforce calling for assistance..."<br><br>Review of the Care Plan revealed, "...Be sure the resident's call light is in reach and encourage to use it for assistance as needed...Resident to use wheel chair for mobility...Extensive assist of one person for transfer..." These interventions had an effective date of 12/26/14, and were in effect prior to the fall on 6/27/15. The facility revised the Care Plan on 6/30/15 to include "Reinforce staying in w/c and calling for help. Resident refuses."<br><br>Review of the Individualized Fall Log for Resident | N 424 | Maintenance Director, Therapy Manager and Medical Director.<br><br>Corporate Nurse will be in facility weekly for four weeks and then monthly for 3 months. | |

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| N 424 | Continued From page 15<br><br>#24 revealed no documentation for the falls occurring during the month of June 2015.<br><br>Medical record review of the Nurses Note dated 7/5/15, timed 9:00 PM, revealed, "Found in BR [bathroom] floor. R [right] L [lower] thigh minimal amount and knee of swelling...Hospice nurse... and I both agreed was minimal damage..."<br><br>Medical record review of the Nurses Note dated 7/6/15, untimed, revealed, "Resident woke up @ [at] 10 A.M. C/O pain to R-thigh et [and] to back when moving left leg. L-foot turned inward...[up] in w/c. Propelling self..."<br><br>Medical record review of the Nurses Noted dated 7/6/15, timed 12:00 PM, "...New orders from...Hospice. Notify Dr [Medical Director]...et order mobile xray..."<br><br>Medical record review of the Nurses Note dated 7/6/15, timed 4:05 PM, revealed, "Mobile imaging called c [with] report of a critical acute R hip fx [fracture]. Dr...notified et order for send to hosp [hospital]. Transfer to hosp @ 5:30/P..."<br><br>Medical record review of the Consultation dated 7/6/15 revealed, "...nursing home patient...had a fall, injuring his right hip...x-rays showed a displaced right hip intertrochanteric fracture...Physical Examination: Shows him holding the right lower extremity in a flexed internally rotated position, and it is very painful to move...Plan: He will be admitted and medically cleared and, once cleared, will undergo ORIF [open reduction internal fixation] of his right hip..."<br><br>Medical record review of the History and Physical for Resident #24 dated 7/7/15, revealed, "...The patient fell at the facility and x-rays revealed a | N 424 | | |

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right hip fracture. The patient is very impulsive and will not seek assistance with transferring or moving and has had multiple medical falls in recent several weeks. There is no head injury with this fall..."

Review of the facility Incident/Accident Report (1 of 2) dated 7/5/15 revealed "...Resident was heard yelling for help, upon staff entering room, resident was found lying in BR on Rt side, minimal amt [amount] swelling noted to R [right] L [lower] thigh and Rt knee...[no] abrasion nor bruising noted...R.O.M. [range of motion] to all extremities...[without] difficulty...Additional comments and/or steps taken to prevent recurrence: Pt instructed [as previously been done] to notify staff for assistance when going to BR. Will evaluate the pt [patient] for body and chair alarms..."

Review of the facility Incident/Accident Report (2 of 2) dated 7/5/15 revealed, "Resident found in B/R [bathroom] floor...[room number] Rt. Knee swollen & bruised... Additional comments and/or steps taken to prevent recurrence: Continue teaching to call for assist before transfers. Encouragement while sore from fall..."

Review of the RCA dated 7/7/15 for the fall on 7/5/15 revealed, "Unassisted transfer. Staff found resident on floor. States he was transferring self to toilet and fell. Poor safety awareness, failure to call for assist with transfer...Additional Information About Event...complained of pain; Xray completed. Found to have a R hip fx [fracture]...Action Plan: Encourage to call for assistance with toileting/transfers..."

Review of the Incident/Accident Report and RCA

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dated 7/5/15, revealed no documentation of the use of alarms, including the presence or functional status of an alarm at the time of the fall.

Medical record review of the Nurses Note dated 7/10/15, timed 11:00 AM, revealed the resident returned to the facility via ambulance. Continued review revealed, "Resident to have pressure pad alarm in bed et w/chair [wheelchair]."

Review of the Care Plan revealed the Care Plan had been revised on 7/10/15 to include "Pressure pad alarm bed & w/c."

Review of the facility Incident/Accident Report dated 7/12/15 revealed, "Resident stated I was just picking up paper off the floor. Found on the floor at bedside, sitting on the floor laughing...Additional comments and/or steps taken to prevent recurrence: One-on-one nursing due to non-compliant..."

Review of the RCA dated 7/14/15 for the fall on 7/12/15 revealed, "...Fall from bed. Resident alarm sounding. Found on floor beside bed. States picking up paper off floor and fell OOB [out of bed]. Laughing. Poor safety awareness. Refuses to call for assistance...Action Plan: One to one by staff due to non-compliance..."

Review of the Care Plan revised 7/12/15 revealed, "One-to-one monitoring d/t [due to] noncompliance with WB [weight bearing] status."

Interview with the Director of Nursing [DON] on 1/13/16 at 11:00 AM, in the Administrator's office, confirmed she had no knowledge of how this intervention had been achieved, or if it was achieved, who monitored the resident, how and

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where it was documented, and if it was even documented. In short, the DON was unable to provide any information to confirm the one-to-one monitoring had been implemented.

Medical record review of the Physician Documentation electronic charting dated 7/13/15 revealed Resident #24 was evaluated in the ER for "complains of Hip Pain,..states he recently had surgery to his right hip- was trying to pick up papers off the floor in his room at the nursing home and he sat down in the floor to do this and then realized he could not get back up. States he felt weak to his legs and could not pick himself up...Disposition: 7/13/15...Discharged to Home. Impression: Condition is Stable..."

Review of the Individualized Fall Log for Resident #24 revealed no documentation for the falls occurring during the month of July 2015.

Review of the Incident/Accident Report dated 8/2/15 revealed "...Resident leaning on side of bed. Fell on to R hip surgical site. Two small cuts one on L wrist and R elbow...Additional comments and/or steps taken to prevent recurrence: Remind to call for Assist..."

Review of the RCA dated 8/4/15 for the fall on 8/2/15 revealed, "...Unassist attempt to get up. Fell against bed. Poor decision making...Action Plan: R hip xray. Remind resident to call for assistance..."

Review of the Care Plan updated 7/30/15 revealed, "...Be sure the resident's call light is in reach and encourage to use it for assistance as needed..." This intervention had an effective date of 12/26/14, and was in effect prior to the fall on 8/2/15. No new interventions were implemented

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for a resident identified as having poor decision making.

Review of the Incident/Accident Report dated 8/8/15 revealed "...resident found in floor next to bed. Resident stated 'trying to put clothes on'...Additional comments and/or steps taken to prevent recurrence: Given call light and instructed to call for help, apply shoes when OOB [out of bed]..."

Review of the RCA dated 8/19/15 (11 days after the fall) for the fall on 8/8/15 revealed, "...Resident found on floor next to bed. Stated he was trying to put his clothes on. Dementia...Action Plan: Given call light and instructed to call for help. Wear appropriate footwear when OOB..."

Review of the Care Plan updated 7/30/15 revealed, "...Be sure the resident's call light is in reach and encourage to use it for assistance as needed..." This intervention had an effective date of 12/26/14, and was in effect prior to the fall on 8/8/15. No new interventions were implemented to prevent falls for the resident identified as having dementia.

Review of the Incident/Accident Report dated 8/10/15 revealed, "...Resident non-compliant c [with] req. [request] assistance with transfers st slid off toilet...Level of Consciousness: Confused as usual...Additional comments and/or steps taken to prevent recurrence: needs to be compliant..."

Review of the RCA dated 8/19/15 for the fall on 8/10/15 revealed, "...Fell 8/10/15, 6:30 PM, Transfer unassisted. Resident toileted self, fell. Dementia, Non-compliant with call...Action Plan:

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| N 424 | Continued From page 20<br>Encourage to call for assistance..."<br><br>Review of the Care Plan updated 7/30/15, "...Be sure the resident's call light is in reach and encourage to use it for assistance as needed..." This intervention had an effective date of 12/26/14, and had not been effective or appropriate for resident #24 who the facility identified as having Dementia, being noncompliant and "confused as usual."<br><br>Review of the Incident/Accident Report dated 8/14/15 revealed "...Resident left nurses station @ 9:50/P to go to room. Came back to nurses station @ 10:10/P [PM] in w/c c blood all over L ear, top of R hand & both knees. States he fell & got back [up] by himself...L ear had an earring in it which is no longer there. Skinned Bil. Knees, abrasions. Skin tear to top of R hand...Level of consciousness: Alert with typical confusion...Additional comments and/or steps taken to prevent recurrence: Resident is non-compliant with req. assistance for transfers..."<br><br>Review of the RCA dated 8/19/15 for the fall on 8/14/15 revealed, "...Unassisted transfer. Transferred self, fell, got self up. Staff noted injuries and asked resident what happened. Dementia. Non-compliance with getting assistance...Action Plan: Spoke with resident regarding safety and potential for injury if does not allow staff to assist. Verbalized understanding..." This intervention had an effective date of 12/26/14, for Resident #24 who had been identified as having dementia, and was non-compliant with asking for assistance.<br><br>Review of the Incident/Accident Report dated 8/20/15 revealed, "...Resident found sitting in floor | N 424 | | |

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| N 424 | Continued From page 21<br>in room. Gotten up and put back in w/c...Additional comments and/or steps taken to prevent recurrence: Do more frequent checks..."<br><br>Review of the RCA dated 10/5/15 (46 days after the fall) for the fall on 8/20/15 revealed, "Self-transfer found on floor in room by staff. Alarm sounding. Dementia...Action Plan: Staff to [check] needs more frequently..."<br><br>Review of the Care Plan dated 7/30/15, and revised 8/20/15 revealed, "More frequent checks for needs." Further review revealed there was no indication of how often or how frequently staff was to check Resident #24.<br><br>Review of the Incident/Accident Report dated 8/27/15, timed 10:30 AM, revealed "...Heard res [resident] yelling. Attempted to open door & resident was against the door. Was finally able to get in room. Found pt [patient] lying on left side...Additional comments and/or steps taken to prevent recurrence: Monitor for safety d/t [due to] [decreased] safety awareness. Frequent checks to pressure pad alarm d/t resident turned it off..."<br><br>Review of the RCA dated 10/6/15 (38 days after the fall) for the fall on 8/27/15 revealed, "...Resident yelling. Found in room on floor, Unassisted transfer...Dementia...To ER for eval and tx:...Action Plan: Frequent checks of alarm due to resident turning off. Alarm placed out of resident reach..."<br><br>Medical record review of the ER Physician Documentation electronic charting dated 8/27/15 revealed, "...complaints of Fall Injury, Pain All Over:..fall today. He states he hurt his left arm, right shoulder and chest wall in the fall...Disposition: Discharged to Nursing Home. | N 424 | | |

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| N 424 | Continued From page 22<br><br>Impression: Arm Sprain, Hip, Fractures - bilateral, repaired, stable. Condition is Stable..."<br><br>Review of the Incident/Accident Report dated 8/27/15, timed 7:00 PM, revealed, "...Resident yelled and was found in room in floor, bleeding from both sides of his head...Additional comments and/or steps taken to prevent recurrence: Remind to call for assistance..."<br><br>Review of the RCA dated 10/6/15 (38 days after the fall) for fall on 8/27/15 revealed, "... Multiple facial lacerations. To ER...Action Plan: Remind resident to call for assistance with needs..."<br><br>Review of the Care Plan dated 7/30/15 and revised on 8/27/15 revealed, "Check alarm frequently due to resident turning off...Keep alarm out of resident's reach..." Further review revealed the facility continued to reissue the intervention of "Remind resident to call for assistance" when the intervention of "Be sure the resident's call light is in reach and encourage to use it for assistance as needed..." was already on the care plan. This intervention had an effective date of 12/26/14.<br><br>Medical record review of the ER Physician Documentation electronic charting dated 8/27/15 revealed, "...presents to ER...with complaints of Fall Injury...The patient fell from an upright position while standing...The patient sustained injury to the head, laceration 5 cm of the left side of forehead...Laceration: Wound Repair of 5cm... subcutaneous laceration to forehead...Skin closed with 8 6.0 Prolene using Simple sutures. Dressed with 4 x 4's [bandage]...Disposition: Discharged to Home. Impression: Head Injury, Forehead Laceration. Condition is Stable.<br><br>Review of the RCA (undated) for a fall on 8/31/15 | N 424 | | |

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revealed, "... Unassisted transfer found by staff lying on bathroom floor. Alarm sounding...Action Plan: Encourage resident to call for assistance with toileting..."

Review of the Care Plan dated 7/30/15 revealed the Care Plan had been revised on 8/31/15 to include "Encourage to call for assistance with toileting." This intervention was implemented for resident #24 who had been identified as confused and noncompliant with calling staff for assistance resulting with falls with injuries.

Review of the Individualized Fall Log for Resident #24 revealed no documentation for the falls occurring during the month of August 2015.

Review of the Incident/Accident Report dated 9/21/15 revealed, "...Resident found sitting in floor beside bed. States 'I was just gonna eat my cookie and popcorn'...Additional comments and/or steps taken to prevent recurrence: Resident to use call light for assist to get OOB..."

Review of the RCA dated 10/6/15 (14 days after the fall) for the fall on 9/21/15 revealed, "...Resident found on floor beside bed. Got up unassisted...Dementia, poor safety awareness...Action Plan: Encourage resident to call staff for assistance d/t danger of fall..." This intervention had been in effect since 12/26/14, and was in effect prior to the fall on 9/21/15. No new interventions were implemented to prevent falls for Resident #24 who was identified as having dementia, poor safety awareness, and "danger of fall."

Review of a facility Incident/Accident Report dated 9/22/15 revealed, "Resident found sitting in bathroom floor naked. Stated I was taking a bath

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| N 424 | Continued From page 24<br><br>in the sink...Additional comments and/or steps taken to prevent recurrence: Resident instructed that he is to use shower room & [and] allow CNAs to assist on sched [schedule]..."<br><br>Review of the RCA dated 10/6/15 (13 days after the fall) for fall on 9/22/15 revealed, "...Resident found sitting on bathroom floor. States taking bath in sink...Action Plan: Resident instructed to get staff assistance for bathing..."<br><br>Review of the Care Plan dated 9/16/15 revealed, "...Extensive assist of one person for bathing..." Staff assistance with bathing was already in effect at the time of the fall. The resident was not cognitively capable of remembering to call for assistance as evidenced by his multiple falls after being instructed to call for assistance and the facility's assessments of dementia, confusion, poor safety awareness, inattention and disorganized thinking.<br><br>Review of the Incident/Accident Report dated 9/24/15 revealed, "...Pt observed sitting on the floor next to his bed, [no] alarm sounding. When pt was asked what happened, he only stated ' I was trying to reach something'...Additional comments and/or steps taken to prevent recurrence: Pt. hide alarm - new chair alarm put in place and functioning..."<br><br>Review of the RCA dated 10/6/15 (11 days after the fall) for fall on 9/24/15 revealed, "...Resident found sitting in floor beside bed. No alarm sounding. Stated he was trying to reach something. Dementia, poor safety awareness...Action plan: Alarm replaced. Put in location out of resident reach. Instructed resident to call staff for assistance..." | N 424 | | |

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| N 424 | Continued From page 25<br><br>Review of the Care Plan revised 8/27/15 revealed, "...Keep alarm in area out of resident's reach and check alarm frequently due to resident turning off..." was already in effect prior to this fall. Continued review revealed no new interventions had been implemented after the fall on 9/24/15.<br><br>Review of the Incident/Accident Report dated 9/26/15 revealed, "...Resident yelling for help, CNA... entered room and resident sitting in the floor by side of his bed. Stated he was trying to adjust pull-up [adult incontinence brief] and ended up losing balance and sat down on floor...Additional comments and/or steps taken to prevent recurrence: Resident instructed to place call light on and ask for help with any needs..."<br><br>Review of the RCA dated 10/6/15 (9 days after the fall) for fall on 9/26/15 revealed, "...Resident heard yelling for help. Found by CNA sitting on floor beside bed. States adjusting his pull-up and lost his balance. Dementia, poor safety awareness, refuses to call for help. Turns off alarm...Action Plan: Instructed to use call light and get staff assistance. Alarm tested...placed out of resident reach..."<br><br>Review of the Care Plan reised 8/27/15 revealed interventions of instructing to use call light, get staff assistance and placing the alarm out of reach had previously been implemented and were ineffective and inappropriate for Resident #24 who was identified as having dementia, poor safety awareness, refuses to call for assistance, and known to turn off safety alarms.<br><br>Review of the Incident/Accident Report dated 9/27/15, timed 3:00 AM, revealed "...Up without w/c @ locker, legs gave way slid down in | N 424 | | |

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floor...Additional comments and/or steps taken to prevent recurrence: Talked with resident about not using his w/c - legs are not strong enough to hold weight..."

Review of the RCA dated 10/6/15 (8 days after the fall) for fall on 9/27/15 revealed, "...Up unassisted at closet. States legs 'gave out'...Fell on floor. Dementia...Action plan: Use w/c - call for staff assistance..."

Review of the Incident/Accident Report dated 9/27/15, timed 6:30 PM, revealed "...Resident states he was trying to get clothes ready for tomorrow and when he stood up came to sitting position leaned up against BR door...Additional comments and/or steps taken to prevent recurrence: Resident verbalized understanding when instructed again to ask for help and put on call light for needs..."

Review of the RCA dated 10/6/15 (8 days after the fall) for the second fall on 9/27/15 revealed "...Up at closet in room unassisted. Dementia...Action Plan: Instructed to use call light and obtain staff assistance. Verbalized understanding..."

Review of the Individualized Fall Log for Resident #24 revealed no documentation for the falls occurring during the month of September 2015.

Review of the Incident/Accident Report dated 10/1/15 revealed, "...Resident observed sitting in floor in front of the toilet in bathroom in his room. Chair alarm present but not sounding due to pt turning it off...Additional comments and/or steps taken to prevent recurrence: Continue to encourage/educate patient to ask for assistance when needed and not to turn chair alarm off."

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Review of the RCA dated 10/6/15 for the fall on 10/1/15 revealed, "...Found by staff sitting on floor in his bathroom. Alarm not sounding, turned off...Demertila, States turned alarm off...Action Plan: Instructed alarm is for safety. Secure alarm on wheelchair and on bed that resident unable to reach. Encourage to call staff for assistance..."

Review of the Care Plan dated 7/30/15, revised 8/27/15 revealed, "...Check alarm frequently due to resident turning off and keep alarm out of resident's reach had previously been implemented, and were ineffective. No new interventions were implemented after the fall on 10/1/15.

Review of the Incident/Accident Report dated 10/2/15, timed 12:30 AM, revealed, "...CNA walking by room at saw resident slide out of w/c on to buttocks...Additional comments and/or steps taken to prevent recurrence: Encourage resident to call for assistance et not turn off chair alarm..."

Review of the RCA dated 10/13/15 (11 days after the fall) for the fall on 10/2/15 revealed "...Staff walking past room saw resident slide out of wheelchair to floor. Landed on buttocks...Action Plan: Encourage resident to call for help. Keep alarm out of resident's reach to prevent him from turning it off..."

Review of the Accident/Incident Report dated 10/2/15, timed 4:15 PM revealed, "...Resident was sitting in chair in room & slid out of w/c. Put to bed... Additional comments and/or steps taken to prevent recurrence: Keep stressing to resident the importance of safety and abide by rules..."

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Review of the RCA dated 10/13/15 for the fall on 10/2/15 for the second fall revealed, "...Resident sitting in room in wheelchair. Slid out of wheelchair to floor..." Action Plan: Encourage resident to call for assistance due to safety..."

Review of the Care Plan dated 7/30/15, revised 10/2/15 revealed, "Encouraged to call for assistance. Put alarm box out of resident's reach. Counseled resident on safety. Need to call for assistance..." Further review revealed these interventions were in effect prior to the fall. No new interventions were implemented for Resident #24 who continued to turn off the personal alarms.

Review of the Incident/Accident Report dated 10/5/15 revealed, "...Resident assisted to bed by CNA, bed straight just as he wanted it. As soon as caregiver left the room he decided to get back up, fell to the floor on his knees, hands on wheelchair...Additional comments and/or steps taken to prevent recurrence: Just keep reminding him and patching him up. Resident reminded to call for help with transfers."

Review of the RCA dated 10/13/15 (8 days after the fall) for the fall on 10/5/15 revealed, "...Got out of bed unassisted after CNA left. Fell to floor on his knees...Action Plan: Remind to call for help with transfer. Alarm replaced - zip-tied to bed/chair out of resident reach..."

Review of the Care Plan dated 9/16/15 revealed, the proposed "Action Plan" from the RCA for "zip-tied to bed/chair out of resident reach" was not implemented on the care plan for the fall on 10/5/15. No new interventions were implemented for the fall on 10/5/15.

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Review of the Incident/Accident Report dated 10/7/15 revealed, "...Entered resident room as he was sliding off bed. Scraped [down] R back on bed railing. Edges would not approximate...Additional comments and/or steps taken to prevent recurrence: Pad the side rails for future possible incidents..."

Review of the RCA dated 10/13/15 for the fall on 10/7/15 revealed, "...Staff entered resident room as he was sliding off edge of bed to floor. Dementia, No safety awareness...Action Plan: Pad side rails to protect skin. Encourage to wait for staff assistance d/t safety..."

Review of the Care Plan dated 6/16/15, and revised 10/7/15 revealed the Care Plan had been updated to include "Pad side rails."

Review of the Incident/Accident Report dated 10/9/15 revealed, "...Resident was heard hollering help. Found resident in front of B/R [bathroom] of his room lying on face. 2 lacerations noted to face...Additional comments and/or steps taken to prevent recurrence: Ice pack applied to hematoma, steri-strips applied to laceration, skin tear cleansed, TAO [triple antibiotic ointment] covered..."

Review of the RCA dated 10/13/15 for the fall on 10/9/15 revealed, "...Resident heard hollering for help. Found lying face down in front of bathroom. Dementia, No safety awareness...Additional information about event...Skin tear x [times] 2 to R arm/elbow. Hematoma R eye. To ER for eval [evaluation] & tx [treat]. Report received R Humerus Fx [fracture], R eye obit Fx, Broken ribs - Admitted..."

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| N 424 | Continued From page 30<br><br>Medical record review of the Physician's Electronic Charting dated 10/10/15 revealed the resident was admitted to the hospital through the ER on 10/9/15 with complaints of Fall Injury. "...Details of fall...fell from upright position, tripped and fell forward...patient sustained injury to the head, injury to the low back, pain with movement, injury to the chest, specifically the right lateral anterior chest and right lateral posterior chest, pain with movement, tenderness, anterior aspect of right shoulder and posterior aspect of right shoulder, decreased range of motion, painful injury. Associated signs and symptoms: Pertinent positives: Chest pain, headache, notes anterior and posterior nose bleed - controlled at this time...the patient experienced no loss of consciousness...symptoms are unchanged. Noted multiple falls - fractured hip 3 months ago. Pt is resident of NH [Nursing Home] Notes that fell forward and face planted. Notes significant facial swelling and bruising to R eye, R shoulder pain, low back, R wrist pain (noted old injury but hurting worse), and R rib/chest wall pain...Transfer ordered to...Medical Center. Diagnosis are Humeral Head Fracture, Orbital Rim Fracture, Rib Fracture, Head Injury, Fall...Condition: Stable..."<br><br>Review of the Care Plan dated 9/16/15 and updated on 10/9/15 revealed "To ER for eval & Tx, Admitted." Continued review revealed no additional entries were made to the Care Plan to address the fall on 10/9/15.<br><br>Review of the Incident/Accident Report dated 10/16/15 revealed, "...Resident did not turn on call light & stood [up] to 'go to the bathroom' fell in floor/hitting R elbow/forearm on bedrail. When nurse entered room he was going down...Additional comments and/or steps taken | N 424 | | |

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| N 424 | Continued From page 31<br><br>to prevent recurrence. Stressed to resident to turn on call light for help..."<br><br>Review of the RCA dated 11/3/15 (17 days after the fall) for the fall on 10/16/15 revealed "...Resident got up unassisted. Alarm sounded. Resident fell as staff walking into room...Dementia, Poor safety awareness...Action Plan: Stress to resident importance of calling staff for assistance..." This intervention was in effect prior to the fall on 10/16/15 and was the same intervention which had remained in effect since 12/24/14, and was ineffective and inappropriate for Resident #24 who had dementia and poor safety awareness. No new interventions were implemented.<br><br>Review of the Individualized Fall Log for Resident #24 revealed no documentation for the falls occurring during the month of October 2015.<br><br>Review of the Incident/Accident Report dated 11/19/15, timed 2:00 PM, revealed, "...Resident attempted to stand at pull [up] his pants [without] calling with call light for assistance. Lost balance et fell in floor...Additional comments and/or steps taken to prevent recurrence: Reiterate to use call light for assistance..."<br><br>Review of the RCA dated 12/9/15 (19 days after the fall) for the fall on 11/19/15 at 2:00 PM revealed, "...Resident stood up to pull up pants and fell. Did not call for assistance...Dementia, poor safety awareness, refusal to ask for assistance...Action Plan: Encourage/remind to call staff for assistance..."<br><br>Review of the Incident/Accident Report dated 11/19/15 at 10:00 PM (2nd fall on this date) revealed, "...Fell in bathroom, states 'I missed my | N 424 | | |

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| N 424 | Continued From page 32 | N 424 | | |

w/c and fell in floor.' c/o right arm, leg (hip), lower back pain...transferred to...ER...Additional comments and/or steps taken to prevent recurrence: Encourage to call for assistance when transferring from chair [to] chair..." Continued review revealed the report was updated on 11/20/15 to include "There. [therapy] to eval for cushion change."

Review of the RCA dated 12/9/15 (19 days after the fall) for the fall on 11/19/15 at 10:00 PM, revealed "...Attempted to transfer self and fell. Dementia, Poor Safety Awareness, Refusal to call for assistance...Action Plan: Therapy to eval/tx d/t chair cushion problem. Pommel cushion to wheelchair for positioning..."

Medical record review of the ER Physician Documentation dated 11/19/15 revealed, "...presents to ER...with complaints of Fall Injury...fell from upright position, while walking...The patient sustained upper back injury, injury to low back, right elbow and right hip...Disposition: 11/20/15...Discharged to Home. Impression: Elbow Contusion, Hip Contusion, Back Contusion. Condition is Stable..."

Review of the Care Plan dated 10/30/15 and revised 11/19/15 revealed "...Therapy to evaluate and change w/c cushion...pommel cushion in w/c for positioning and to prevent sliding..."

Review of the Incident/Accident Report dated 11/25/15 revealed, "...Resident had turned off own alarm. Upon entering room to ck [check] on him, found in floor with blood from other resident's bed to his. States 'putting pillow on bed and lost balance'...Additional comments and/or steps taken to prevent recurrence: Reinforced to resident to leave alarm on as we can't tell if he

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| N 424 | Continued From page 33<br>needs us..."<br><br>Review of the RCA dated 12/16/15 (20 days after the fall) for the fall on 11/25/15 revealed, "...Resident found in his room on floor beside bed. Was putting pillow on bed and lost his balance. States he turned alarm off. Dementia, poor safety awareness...Action Plan: Reinforce with resident to leave alarm on so that staff can come provide assistance. Instructed to call staff for assistance with pillows..."<br><br>Review of the Care Plan dated 10/30/15, revised 11/25/15, revealed "Reinforced leaving alarm turned on to alert staff of need for assistance." This intervention was in effect prior to the fall and had proven to be ineffective for Resident #24, who had continued to turn personal alarms off. No new interventions were implemented.<br><br>Review of the individualized Fall Log for Resident #24 revealed no documentation for the falls occurring during the month of November 2015.<br><br>Review of the Fall Risk assessment dated 12/1/15 revealed the resident scored 25 indicating the resident was high risk for falls (Total score of 10 or above represents high risk).<br><br>Review of the Incident/Accident Report dated 12/3/15 revealed, "...Heard knocking on wall, found resident sitting in floor in front of toilet. States "I missed the seat"...Nurse questioned why didn't use call-light. Resident states "I ain't gonna call - I can do it myself"...Additional comments and/or steps taken to prevent recurrence: Cont [continue] to re-inforce resident to call for assist..."<br><br>Review of the RCA dated 12/16/15 (12 days after | N 424 | | |

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| N 424 | Continued From page 34<br>the fall) for the fall on 12/3/15, revealed, "...Staff heard knocking on wall, found resident sitting on floor beside toilet. States he missed the seat. Dementia, poor safety awareness, refusal to call for assistance...Action Plan: Reinforce with resident to call staff for assistance..."<br><br>Review of the Care Plan dated 10/30/15 revealed no new interventions were implemented for the fall on 12/3/15 to prevent falls.<br><br>Review of the Incident/Accident Report dated 12/13/15 revealed, "...Resident stood up and his knees collapsed, fell to floor, knocked scab off R arm, below elbow. [no] other injuries...Additional comments and/or steps taken to prevent recurrence: Educate resident on asking for help when he needs to stand..."<br><br>Review of the RCA dated 12/16/15 for the fall on 12/13/15 revealed, "...Resident stood up, knees collapsed and he fell to the floor - unassisted transfer - Dementia, weakness...Action Plan: Remind resident to ask for staff assistance with transfers due to weakness..."<br><br>Review of the Care Plan dated 10/30/15, revised 12/13/15 revealed, "Educate resident on asking for help when he needs to stand." This intervention was in effect prior to the fall and had not been effective for Resident #24 who had Dementia . No new interventions were implemented.<br><br>Review of the individualized Fall Log for Resident #24 revealed no documentation for the falls occurring during the month of December 2015.<br><br>Review of the RCA (undated) revealed, "Fall 1/5/15...Resident found by staff sitting on floor | N 424 | | |

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beside bed. Stated he was trying to get his wallet from under the bed. States he turned alarm off...Action Plan: Remind resident to leave alarm in place for safety. Remind resident to call for assistance..."

Review of the Care Plan dated 10/30/15 revealed no new interventions had been implemented for the fall on 1/5/16, and the proposed "Action Plan" had been ineffective previously for preventing falls for Resident #24.

Observation on 1/11/16 at 4:30 PM, revealed Resident #24 self-propelling in his wheel chair down the hallway an alarm attached to the hand grip on the resident's chair.

Observation on 1/12/16 at 8:35 AM in the front lobby, revealed the resident seated in a wheel chair revealed the chair alarm attached to the hand grip on the wheel chair.

Interview with Licensed Practical Nurse (LPN) #1 on 1/12/16 at 8:42 AM at the Main Nurse Station confirmed, "...thought he could reach the alarm in it's current location on the hand grip of the wheel chair..."

Interview with CNA #8 on 1/12/16 at 8:50 AM, at the nurse's station, confirmed "...I think he could reach it where it is now, but it is better than when we put it under the wheel chair; he almost fell out on his head trying to get to it..."

Interview with the Rehabilitation Manager on 1/12/16 at 10:03 AM, in the Administrator's office, revealed "I have been working with him for the past 6 years...He wants to get stronger...His judgement is very poor; poor safety awareness...He will not ask for assistance; when

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| N 424 | Continued From page 36<br><br>he is in a certain state of mind he is almost inconsolable, impulsive...We couldn't say he is consistent with his comprehension, flight of mind. The rehab manager confirmed he would recall at the moment to call for assistance, but if he had the thought to get up he would just get up...remembers 10% or less of recall of safety measures.<br><br>Interview with the DON on 1/13/16 at 11:15 AM, in the Administrator's office confirmed Resident #24 had 48 falls occurring from January 31, 2015 to January 5, 2016, and 4 of the falls (6/27/15, 7/5/15, 8/27/15, 10/9/15) resulted in harm to Resident #24. Continued interview confirmed Resident #24's individual Fall Log had not been updated since 4/30/15. Continued interview confirmed the facility had not attempted to address the resident's non-compliant behavior. Continued interview confirmed current interventions to encourage, remind, and instruct the resident were inappropriate and had been unsuccessful in preventing falls. Continued interview confirmed of the resident's 48 falls, 44 of the falls had either inappropriate or no new interventions implemented for the prevention of falls. Continued interview confirmed alarms had not been effective in preventing the resident from falling.<br><br>Interview with the Medical Director on 1/13/15 at 12:15 PM, in the Administrator's office, confirmed the resident "does not listen to redirection and is very hard to redirect...doesn't matter what you want him to do, he will do what he wants to do...behaviors have to do with medical condition..." Further interview with the Medical Director confirmed, "In my opinion he has poor judgement, poor impulse control, and poor decision making ability. Education, redirection, | N 424 | | |

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and encouragement would not improve his behavior and in 10 minutes he has likely forgotten the education, redirection, and encouragement."

Interview with the DON on 1/15/15 at 8:43 AM, in the Administrator's office confirmed the DON was aware the resident had multiple falls. Continued interview confirmed the facility failed to follow their Post-Fall Protocol and had not implemented new interventions to prevent the recurrence of falls after each fall; had not completed Fall Risk assessments timely; and had not updated Resident #24's Fall Log.

In summary, Resident #24 had 48 falls between January 31, 2015, and January 5, 2016. There were 32 falls with no new interventions added to the Care Plan after the fall; ineffective and repetitive interventions, for example, "Be sure the resident's call light is in reach and encourage to use it for assistance as needed..." and "...Reminded resident not to turn off alarm..." were used repetitively for 29 falls. In consideration of the lack of individualized interventions and monitoring to prevent falls, the facility failed to protect Resident #24 from falls.

Medical record review revealed Resident #26 was admitted from a hospital stay in a gero-psych unit on 7/29/15, with diagnoses including Dementia with Behaviors, Depression, Degenerative Joint Disease and Type II Diabetes.

Medical record review of Resident #26's care plan dated 8/7/15 revealed "...The resident is at risk for fall..." Interventions included "...Anticipate and meet the resident's needs...Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed...Ensure that the resident is wearing

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| N 424 | Continued From page 38<br><br>appropriate footwear... Follow facility fall protocol. Keep items of frequent use within resident reach. PT [Physical Therapy] evaluates and treats as ordered or PRN [as needed]..."<br><br>Review of a facility Incident/Accident report dated 8/28/15 revealed on 8/28/15 at 4:45 PM in hallway "...Resident was walking up hallway and she made a noise and I turned to see her starting to fall. She started bleeding from her head (Back of head) and c/o [complained of] L [left] hip pain..." Continued review revealed no steps documented on the report "to prevent recurrence."<br><br>Review of the RCA for the 8/28/15 fall revealed Resident #26 was walking in hallway using a walker and fell backwards. Continued review revealed the RCA did not identify factors present when the resident fell, did not include any witness statements, and the Action Plan was "To ER (Emergency Room) for evaluation and treatment."<br><br>Medical record review of a History and Physical from a local ER, dated 8/28/15, revealed "...resident... [in local skilled facility]...fell...injuring her head and left hip. She was brought into the ER for evaluation and found to have a left femoral neck fracture [hip fracture]..."<br><br>Medical record review of an Operative Note dated 8/31/15 revealed Resident #26 had a Hemiarthroplasty (Hemiarthroplasty is a surgical procedure that replaces one half of the hip joint with a prosthetic, while leaving the other half intact) of the left hip on 8/31/15.<br><br>Medical record review of Physician's Orders dated 9/2/15 revealed Resident #26 was readmitted from the hospital to the facility on | N 424 | | |

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| N 424 | Continued From page 39<br>9/2/15.<br><br>Medical record review of a Fall Risk Assessment dated 9/7/15, revealed a score of 15. Continued review revealed a score above 10 represented "HIGH RISK."<br><br>Medical record review of the care plan dated 9/7/15 revealed no additional interventions for falls prevention after the 8/28/15 fall with fracture, or after return to the facility on 9/2/15.<br><br>Review of a facility Incident/Accident Report dated 10/14/15 revealed Resident #26 had a fall on 10/13/15 at 11:30 AM. Continued review revealed "...called to activity/therapy room. Resident found on back with laceration to back of head. c/o R [right] hip/back pain...physician and family notified....steps taken to prevent recurrence first aid applied, sent to ER, pressure pad alarm in bed and w/c [wheelchair]..." Continued review revealed the nursing staff recommended the pressure pad alarm on the Incident Report and it was added to the care plan, "Pressure pad alarm to bed and wheelchair."<br><br>Review of facility records revealed the RCA investigation for the 10/13/15 fall was not done.<br><br>Medical record review of a daily Skilled Nurse's Note dated 10/13/15, revealed Resident #26 returned to the facility at 4:00 PM. Continued review revealed the resident had a repair to the scalp laceration with staples. Continued review revealed "...[Resident #26] Attempted X [times] 5 to get up unassisted..."<br><br>Medical record review of a Fall Risk Assessment dated 11/11/15 revealed a score of 20 which indicated a High Risk. | N 424 | | |

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Review of an Incident/Accident Report revealed a fall occurred on 11/28/15 at 11:15 AM in the front lobby. "...resident found on floor in front lobby, w/c alarm sounding...cut to R hand dorsal [top] aspect...first aid given...physician and family notified...steps taken to prevent recurrence "Toilet resident et put resident to bed for a nap..." Further review revealed the Incident Report was not completed, the part of the report "Describe exactly what happened" was empty and there were no witness statements.

Medical record review of a Nurses Note dated 11/28/15 at 12:50 PM, revealed an entry pertaining to the morning fall, "...Resident slid out of w/c to floor, and did not hit head. Small cut to R dorsal hand, cleansed... and band aid applied...Res had been agitated wanting to go to bed. Res ate lunch, toileted et [and] laid down for nap until supper. This nurse asked CNA to toilet resident q 2 & PRN [every 2 hours and as needed]..."

Review of the facility records revealed a RCA form for the 11/28/15 fall at 11:15 AM fall did not have an investigation completed. The Action Plan "Toilet resident and put to bed for a nap" did not define when the intervention was to be done.

Review of an Incident/Accident Report revealed a fall occurred on 11/28/15 at 3:30 PM. Continued review revealed "...Resident not seen when fall occurred, fell from wheel chair to floor from what resident said..."

Medical record review of Nurse's Notes dated 11/28/15 at 3:30 PM revealed "...Resident fell out of w/c and hit floor. Res c/o L hip pain... [Physician] directed this nurse to send resident to

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| N 424 | Continued From page 41<br>ER for evaluation..."<br><br>Review of the RCA form for the 11/28/15 afternoon fall revealed a retelling of the same information on the Incident Report and no contributing factors or root cause was identified.<br><br>Medical record review of the care plan revealed on 11/28/15 the interventions for the two falls on that date were "Toilet resident and put down for a nap...To ER for eval and Tx ...Encourage to call for assistance with transfer (a repeat of a previous intervention).<br><br>Review of an Incident/Accident report revealed a fall occurred on 12/25/15 at 6:50 AM at the nurses' station. "...Resident stood up from w/c. Took a step and fell on floor on L side resulting in hematoma [swelling from bleeding into subcutaneous tissues] to L. temple. c/o pain to L. femur/knee. Sent to ER..."<br><br>Medical record review of a facility Transfer Form and Documentation dated 12/25/15 revealed "...slower to respond...stood up-fell on L side of body hitting L. side of forehead causing hematoma to L. temple..."<br><br>Medical record review of the Care Plan dated 8/7/15, updated on 12/25/15, revealed a new intervention of "...Alarm replaced..."<br><br>Medical record review of a hospital consultation note dated 12/25/15 at 3:46 PM "...sustained a ground-level fall earlier this morning at her nursing home. There was obvious head trauma and loss of consciousness. She was taken to [local hospital] where x-rays and scans were performed and then transferred to [this hospital] for definitive care..." | N 424 | | |

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Medical record review of a CT scan of the head dated 12/25/15 revealed "...There is a large anterior parietal scalp hematoma. No underlying fracture is seen. There are few small foci of high density outside the brain that were not present in October 2015, consistent with hemorrhage. This is an atypical pattern of hemorrhage..."

Medical record review of an Orthopedic consultation report dated 12/28/15 revealed Resident #26 had a periprosthetic hip fracture after the fall on 12/25/15, with a revision of the left hip hemiarthroplasty with open reduction and internal fixation of the proximal femur on 12/27/15.

Medical record review of Transfer Orders-Patients Discharged to SNF/Rehab dated 12/28/15 revealed "...L periprosthetic hip fx s/p [status post] revision/ORIF (open reduction and internal fixation)..."

Medical record review of a nursing note dated 12/29/15, at 2:10 PM revealed "...Resident arrived via stretcher from...hosp..."

Review of a Root Cause Analysis dated 1/7/16 revealed "...fall on 12/25/15 on 6:50 am, Resident stood up from w/c took step then fell to floor...Hematoma to L temple c/o pain L upper leg/knee. To ER for eval and Tx. Admitted for L hip fx, cerebral bleed..." The investigation did not include any witness statements, whether the pressure alarm was sounding, or any other pertinent details. Further review revealed no conclusions of a root cause or contributing factors.

Observation on 1/12/16 at 5:27 PM revealed

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| N 424 | Continued From page 43<br><br>Resident #26 in bed, asleep, the call light on the pillow.<br><br>Observation of Resident #26 with the treatment nurse, on 1/13/16 at 11:47 AM, in the resident's room, revealed the resident asleep in bed and the call light was in the laundry bin. Continued observation revealed no bed alarm present.<br><br>Telephone interview with LPN #5 on 1/13/16 at 7:41 AM revealed "... During the [11/28/15 at 11:15 AM] fall I was on my way to the front lobby because another resident alarm was going off but he sat back down. She [Resident #26] slid down to floor. She was exit seeking that day. She kept saying she wanted to go home. I brought her back to nurse's station and talked with her...Asked her if she need to go to bathroom, and she responded "I don't know". I asked her if she needed to go to bathroom because that is what she needs sometimes. I thought it would remedy the situation. I filled out the incident report and put it in the DON box. I do not recall leaving the description of exactly what happened section blank, I thought I filled it out. I didn't put her back to bed like it said in the nurse's note because she will get herself right back up. She transfers herself quite often..."<br><br>Interview with the DON on 1/12/16 at 3:02 PM, in the Administrator's office, revealed Resident #26's first fall on 8/28/15 occurred in the hallway, "...The fall interventions were in place prior to fall. After the fall the new intervention put in place was to send to ER for evaluation and treatment. The resident was walking at the time of the fall..." Continued interview revealed the second fall on 10/13/15 occurred in the activity therapy room, "...All previous interventions were in place. New interventions initiated were pressure pad alarm to | N 424 | | |

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bed and wheelchair. The resident was receiving PT [physical therapy] and OT [occupational therapy] also but that is not on the typed care plan..." The third fall occurred on 11/28/15 at 11:15 AM in the front lobby. "...I don't know who she was found by, how the fall happened or why that intervention [toilet resident and put to bed] was chosen it is not on the incident report. Continued interview revealed the fourth fall occurred on 11/28/15 at 3:30 PM in Resident #26's room. "...All the interventions were in place prior to the fall. A new intervention was put in place to "Encourage to call for assist with transfer..." Continued interview confirmed "...Based on her BIMS score [5] that is not an accurate intervention for her..." Continued interview revealed the fifth fall occurred on 12/25/15 at the nurse's station "...she was found by [LPN #1] I will let you talk to her about questions about this incident..."

Interview with the DON on 1/12/15 at 4:12 PM, revealed "Moved to room 103 near nurse's station on 9/2/15."

Interview with LPN #1 on 1/12/16 at 4:12 PM, in reference to the 12/25/15 fall sustained by Resident #26, revealed "...The intervention 'Maintain assess safety precautions' is referring to making sure alarms are on and working and monitoring the resident. The alarm was silenced and appearing not to work in the w/c. I did not hear it go off. I wrote a statement about the alarm not working on her wheelchair and gave it to the DON. I will go get it..."

Interview with LPN #1 on 1/12/16 at 4:16 PM, in the Administrator's office, revealed "... They don't have it..." (referring to the written statement about the alarm not working).

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Interview on 1/12/16 at 4:33 PM, with the DON in the DON/ADON office revealed, "We discuss all incidents in morning meetings...Look at why happened...look at interventions that are in place. Then root cause analysis is done. This 11/28/15 incident report is incomplete. The investigation was done, the MDS nurse does the root cause analysis. She talks with the staff and looks at the nurse's notes...I never received a written statement from [LPN #1] after [Resident #26] fell and re-fractured her hip..."

Interview with LPN #1 on 1/13/15 at 2:17 PM, at the nurses' station, revealed on the day of the 12/25/15 fall, " ...a 3rd shift CNA put Resident #26 in her wheelchair prior to 7:00 AM. Her CNA that day on that shift was in another room. Her CNA tested the alarm after the incident and she saw there was a delay." Continued interview revealed "...I was at my cart and I was within 3 feet of her when she had her fall and I did not here the alarm going off. It was silenced..."

Interview with the DON on 1/13/16 at 10:53 AM, in the Administrator's office revealed the new intervention put in place after the 8/28/15 fall with fracture was to send Resident #26 "to ER for eval and tx". Continued interview with the DON confirmed that was not an intervention for falls prevention and confirmed no new interventions were put in place when Resident #26 came back to the facility from the hospital after the 8/28/15 fall. Continued interview revealed "...The prior intervention of wheel chair alarm on 12/25/15 was ineffective if it was not working..." Continued interview confirmed the falls policy was not followed on 10/13/15 as vital signs were not documented, and on 11/28/15 as the Incident/Accident reports were not completed.

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Continued interview confirmed Resident #26 had no fall logs done by the MDS coordinator as required by the facility's fall policy.

In summary, Resident #26 had 5 falls between August 28, 2015, and December 25, 201. There were 2 falls with no new interventions added to the Care Plan after the fall; ineffective interventions, for example: " to ER [emergency room] for eval and Tx [evaluation and treatment], and "Alarm replaced". In consideration of the lack of individualized interventions and monitoring to prevent falls, the facility failed to protect Resident #26 from falls.

Medical record review revealed Resident #23 was re-admitted from the hospital on 1/19/15 with diagnoses including Recent History of Pneumonia, Alzheimer's Dementia, Parkinson's Disease, Type 2 Diabetes, and Cerebral Vascular Disease.

Medical record review of the six FALL RISK evaluations completed for 1/19/15 through 11/23/15 revealed the resident was a "High Risk" for falls. Continued review revealed all the evaluations for 2015 assessed a balance problem while walking and decreased muscular coordination.

Medical record review of Resident #23's Nurse's Notes revealed the resident fell 4/23/15, "Resident got self OOB [out of bed] unassisted the am [morning] and rolled up hallway in nightgown...dining room for breakfast...2:20 pm-Resident was sitting outside therapy room and this nurse heard a loud noise...attempted to stand unassisted with walker & [and] when sitting down in w/c [wheel chair] she missed the chair & fell into fire door. c/o [complaining of] HA

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| N 424 | Continued From page 47<br><br>[headache], elbow pain, and backache...Tylenol PO [by mouth] placed in therapy room with [rehab staff] after fall...PEARL [pupils equal and reactive to light] noted..."<br><br>Review of the medical record revealed the resident (a Diabetic) did not have her blood sugar checked as required by the Post-Fall Policy. Continued review of the medical record for the following 5 days revealed no further neurological assessment of the pupils or movement of the extremities was done.<br><br>Medical record review of the resident's Care Plan to address falls, initiated 12/03/2014 and continued at re-admission on 1/19/15, revealed "...at risk for falls ..." Review revealed the interventions for the high risk of falls included: Anticipate and meet the resident's needs; Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed; The resident needs prompt responses to all requests for assistance; Ensure that the resident is wearing appropriate footwear; Falls risk assessment quarterly, with significant change, and prn [as needed]; Follow facility fall protocol; Keep items of frequent use within resident reach; Pt [physical therapy] evaluate and treat as ordered or PRN (physical therapy treated the resident from 1/20/15 through 4/28/15).<br><br>Review of the Incident/Accident Report dated 4/23/15 recorded the fall happened at 2:00 PM (the Nurse's Note stated 2:20 PM). Continued review revealed..."Resident states Bumped head on door..." Review of the RCA for the 4/23/15 fall revealed the investigation was completed on 7/7/15 (75 days after the fall) and repeated the intervention recorded on the Incident Report "resident instructed not to stand without | N 424 | | |

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assistance." This intervention was not added to the plan of care and no other new interventions were developed in an effort to prevent further falls.

Medical record review of the Nurse's Note dated 5/17/15 revealed, "Resident found in hallway floor...No witness to fall...area below (L) [left] knee...sheared..."

Review of the Incident Report dated 5/17/15 revealed the fall happened at 4:00 AM. "Resident got up out of bed after voiding on the side of the bed walked to the hallway door holding onto furniture before sliding onto the floor ...needs bed alarm for pull tab to let us know when she decides to walk."

Review of the RCA for the 5/17/15 fall revealed the investigation was completed on 7/7/15 (50 fifty days after the fall) and did not address the resident's voiding needs that was stated in the "Details" of the Incident Report for the fall. The "Bed Alarm" was a new intervention added to the original interventions and was dated 5/17/15 on the care plan.

Medical record review of the Nurse's Notes dated 5/24/15 revealed "3AM. Resident found lying in floor between beds...moves all four extremity...assisted to bed..." Further review of the Nurse's Note revealed there was no mention of who found the resident, if the resident offered any comments, no vital signs or neuro checks included, no record of a blood suger being checked, or if there were any injuries noted.

Review of the facility's records confirmed Resident #23's 5/24/15 fall was not reported on an Incident Report and was not investigated with

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| N 424 | Continued From page 49<br>the facility's required RCA.<br><br>Medical record review of the Care Plan revealed on 5/24/15 the Care Plan was updated 3 times with the same interventions which had already been implemented on the care plan"Keep items of frequent use in reach"; "Remind to use call light for Assistance"; and the third intervention dated 5/24/15, "Remind resident not to push other residents due to safety." The interventions were not new interventions and had been ineffective and inappropriate for the cognitively impaired resident.<br><br>Medical record review of the Nurse's Note dated 5/25/15 revealed, "BA-1p 0 [zero] s/s [signs or symptoms] of injury from fall during AM hours ...0 complaints of pain at this time. Resident OOB [out of bed] in w/c to DR [dining room]. Resident exited DR and tried to push another resident's w/c in front of her and scooted from her w/c onto the floor...bruise to left wrist and hand..."<br><br>Review of the facility's records confirmed Resident #23's fall of 5/25/15 from the wheelchair was not reported on an Incident Report and was not investigated with the facility's required RCA.<br><br>Review of the care plan revealed no new intervention developed after the 5/25/15 fall. The intervention dated 5/24/15 to "Remind resident not to push other residents due to safety" was dated 5/24/15 and was not appropriate for the resident who had severe cognitive impairment assessed by the facility and both short and long term memory problems.<br><br>Medical record review of the Nurse's Notes dated 5/27/15, revealed "12 AM Heard resident say 'Oh my' Resident states 'I was trying to get key for my | N 424 | | |

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car outside." Nurse redirected resident. Resident found sitting in floor. Denies any pain or discomfort, no redness or bruising noted ...Assisted back to bed, moves all four extremities per self ..."

Review of the Incident Report dated 5/27/15 revealed the resident stated she was " ...getting up to go check my car outside."

Review of the RCA for the fall of 5/27/15 revealed the investigation was completed on 7/7/15 (40 days after the fall) and recorded in the investigation the resident's "Dementia, confusion, and poor safety awareness" was a "relevant" factor. Review revealed the interventions were to reorient and redirect when delusional.

Review of the care plan revealed "when delusional" was not included.

Review of the Incident Report dated 6/1/15 revealed a fall happened at 3:30 PM as the "Resident rolled down hall B in w/c toward her room when she decided to come back up hall she then proceeded to slide out of her chair onto floor..." The report does not identify the staff member who witnessed the fall. The recommended intervention on the Incident Report was to "Remind resident prn [as needed] not to sit on edge of w/c (wheelchair) seat" (resident assessed 5/15/15 to have severe impairment with both long and short term memory).

Review of the RCA for the fall of 6/1/15 revealed the investigation was completed on 7/7/15 (36 days after the fall) and added the intervention of "Remind resident not to set on edge of w/c seat" (resident assessed 5/15/15 to have severe mental impairment with both long and short term

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| N424 | Continued From page 51<br><br>memory problems).<br><br>Medical record review of the care plan developed from the comprehensive Annual assessment, dated 11/9/15, revealed the interventions were provided by the software program and populated into the updated care plan: Anticipate and meet the resident's needs; Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed; The resident needs prompt responses to all requests for assistance; Ensure that the resident is wearing appropriate footwear; Falls risk assessment quarterly, with significant change, and prn; Follow facility fall protocol; Keep items of frequent use within resident reach; PT (physical therapy) evaluate and treat as ordered or PRN (physical therapy treated the resident from July 2015 through August 15, 2015 to address safe transfers with a rolling walker and standby assist with verbal cues). Continued review of the care plan revealed the bed alarm was not included as an intervention and all the interventions were the same computer-generated interventions on the previous care plan.<br><br>Medical record review of the Nurse's Note dated 11/22/15 revealed, "Resident hallucinating this shift first time she thought she saw her son and went after him. Resident fell on the floor at bedside no injury noted..."<br><br>Review of the Incident Report and physician orders revealed the resident was treated for a urinary tract infection.<br><br>Medical record review of the Nurse's Note dated 12/21/15 revealed, "4:00 pm Heard Resident yell out - went to room, found resident on the floor by her bed. She had attempted to get in bed and | N 424 | | |

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| N 424 | Continued From page 52<br><br>unable to make it ...4:45 pm Transfered to Hospital for evaluation..."<br><br>Review of the Incident Report for a fall on 12/21/15 revealed, "4:00 PM "Resident yelled out and was found lying in floor by her bed. Forehead had two small knots..." Continued review revealed "...steps taken to prevent recurrence: To ER for evaluation...Bed alarm (checked), new Batteries."<br><br>Review of the RCA for the 12/21/15 fall revealed the investigation resulted in an entry on the care plan, "12/21/15 Fall - hematoma forehead, skin tear to finger - To ER for evaluation & Tx" and under the intervention column of the care plan "Alarm tested-batteries changed (this is an expectation to maintain the functioning of a previous intervention) and Pressure pad alarm to chair/bed (a previous intervention for a bed alarm was on the care plan 12/03/14).<br><br>Interview with the DON on 1/15/16 at 10:05 AM, in the administrator's office, confirmed the pressure pad alarm was added to Resident 23's wheelchair and the date this began was not documented in the care plan and the date could not be determined.<br><br>Review of the emergency room Physician Order's and Progress Notes dated 12/21/15 revealed the resident had x-rays of the right knee and a CT of Head with diagnoses of "Knee Contusion and Head Injury."<br><br>Observation of the resident on 1/11/16 at 8:30 AM, revealed the resident was up in the wheel chair in the hall, close to the nursing station,with the pressure pad in the seat of the w/c. | N 424 | | |

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Interview with Resident #23 on 1/15/16 at 8:15 AM, in the rehab room revealed the resident did not readily engage in conversation. When asked about the last fall in December at 4:00 PM, she responded, "They won't put you to bed when you asked to be...they say you have to stay up longer..."

Interview with the DON on 1/15/16 at 10:05 AM, in the administrator's office, confirmed the resident did not have a blood sugar checked after all the falls from 5/24-12/21/15; a series of neuro checks were not done after the fall with "head bumped" on 4/23/15, and were not done after the next seven unwitnessed falls. Further interview confirmed after the fall 4/23/15, no new interventions were put into place and there was no Incident Report or RCA investigation for the falls on 5/24/15 and 5/25/15. Further interview confirmed Resident #23 had repeated falls and did not have an individual falls log as required by the facility's Post-Fall Protocol. Interview confirmed the plan of care did not include an effective intervention to assist in fall prevention following the 5/17/15 fall with the use of a bed alarm and, after the next 6 falls, the interventions were a repeated intervention or not an effective intervention due to the resident's impaired cognitive status. Interview continued and confirmed the resident's fall of 12/21/15 resulted in a head injury, the resident's pressure pad had already been in use in her wheel chair prior to the 12/21/15 fall and maintaining the proper functioning of the alarm was not a new intervention.

In summary, Resident #23 had 8 falls between April 23, 2015, and December 21, 2015. There were 7 falls with no new interventions added to the Care Plan after the fall. In consideration of the

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| N 424 | Continued From page 54<br>lack of individualized interventions and monitoring to prevent falls, the facility failed to protect Resident #23 from falls.<br><br>Resident #40 was admitted to the facility on 7/17/15 with diagnoses including Senile Dementia with delusional features, Difficulty in Walking, Depressive Disorder, Diabetes Mellitus, Hypertension, and Insomnia.<br><br>Medical record review of a Fall Risk Assessment dated July 17, 2015, revealed the resident received a score of 13, with a total score above 10 indicating the resident was a high risk for falls.<br><br>Review of the Incident/Accident Report dated 7/19/15 revealed the resident was found sitting in the floor in her room (unwitnessed fall). Continued review revealed the resident "...stated she just sat down..." Further review revealed "...Additional comments and/or steps taken to prevent recurrence: Keep in area visible by staff when awake. Put alarm out of reach..."<br><br>Medical record review of the Interim Care Plan, last updated 7/19/15 revealed the resident's care plan was updated to reflect the resident had a fall with no injury on 7/19/15 (2 days after entering the facility). Continued review revealed the facility implemented new intervention to prevent future falls "...Bed alarm...keep resident in area visible by staff when up walking around...put alarm box out of resident reach..."<br><br>Review of the RCA, not dated, revealed, "...Why did it happen?...1. Self transfer 2. Found sitting on floor next to bed, states she sat down on floor, alarm not sounding. Turned off...Dementia...Action Plan...1. Resident states she turned alarm off. Keep alarm in position | N 424 | | |

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| N 424 | Continued From page 55 | N 424 | | |

where resident cannot reach...2. Keep resident in area visible by staff when awake..."

Medical record review of Resident #40's care plan, date initiated 7/29/15 revealed, "...The resident is at risk for falls r/t history of falls, decreased mobility, use of psychotropic medication..." Continued review revealed, "...Interventions/Tasks...7/19/15- Keep resident in area visible by staff when not sleeping; 7/19/15- Put alarm control box out of resident's reach; Anticipate and meet the resident's needs; Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; Ensure that the resident is wearing appropriate footwear; Fall risk assessment quarterly, with significant change and prn. Follow facility fall protocol; Keep items of frequent use within resident's reach; Pressure pad alarm in bed; PT evaluate and treat as ordered or PRN..."

Review of an Incident/Accident Report dated 8/7/15 and timed 7:00 PM revealed the resident had an unwitnessed fall in the dining room "...Heard loud noise from dining room. Found resident lying on her back. No injuries. Res has been amb [ambulating] with unsteady gait leaning to the right..." Continued review revealed, "...Additional comments and/or steps taken to prevent recurrence: Frequent rest periods..."

Review of the RCA, dated 8/19/15, for the fall on 8/7/15 (12 days after the fall) revealed, "...Why did it happen? 1. Ambulating...Dementia, unsteady gait, leaning to one side...Action Plan 1. Frequent rest periods..."

Review of an Incident/Accident Report dated

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| N 424 | Continued From page 56<br><br>8/11/15 and timed 9:15 PM revealed the resident had an unwitnessed fall in the hall "...Resident would not stay in bed or chair. Had been walking up and down hall in and out of all rooms. RN [Registered Nurse] heard noise back hall and found resident on the floor by the sink..." Continued review revealed, "...Bring resident out with staff when restless..." Continued review revealed the intervention implemented was not a new intervention as a prior intervention on the resident's care plan was "...7/19/15...keep resident in area visible by staff when not sleeping..."<br><br>Review of the RCA dated 8/19/15 (8 days after the fall on 8/11/15) revealed, "...1. Resident restless, would not stay in bed. Pacing. Staff heard noise, found resident on the floor...Dementia...Action Plan: 1. Bring resident out staff when restless..."<br><br>Review of the Incident/Accident report dated 8/14/15 and timed 1:30 PM revealed the resident fell in the activity room (unknown if witnessed) "...Resident was ambulating, wandering- fell in activity room, pt [patient] assisted up by 3 nurses...red area 2 inch by 2 inch note backside of L arm..." Continued review revealed "...Additional comments and/or steps taken to prevent recurrence: Ensure rest periods when wandering..." (prior intervention implemented on 8/7/15).<br><br>Review of the RCA dated 8/19/15 for the fall on 8/14/15 at 1:30 PM, revealed, "...1. Fall...2. Resident wandering throughout unit. Fell in activity room...Dementia...Action Plan: 1. Ensure rest periods when wandering..."<br><br>Review of an Incident/Accident Report dated | N 424 | | |

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| N 424 | Continued From page 57 | N 424 | | |

8/14/15 and timed 5:00 PM revealed the resident had an unwitnessed fall in her room, "Res. [resident] found lying on floor of her room. Large hematoma noted to back of her [head] No change in LOC [level of consciousness]..." Continued review revealed, "...Additional comments and/or steps taken to prevent recurrence: keep resident in activity room with staff...Accompany to room for needs..." Continued review revealed the interventions implemented were not new interventions as prior interventions on the resident's care plan were 7/19/15 keep resident in area visible by staff when not sleeping; 7/29/15 anticipate and the resident's needs; and 8/11/15 when restless keep resident in area visible by staff.

Medical record review of a nurse's note dated 8/14/15 revealed the resident was transferred to a local emergency room for evaluation after the fall. Continued review revealed the resident returned to the facility the same evening with "...no new orders..."

Review of the RCA dated 8/19/15 for the fall 8/14/15 at 5:00 PM revealed, "...1. In room...2. Found lying on floor in room. Unwitnessed fall...Dementia, wanders...Action Plan...1. Keep resident in Activity room with staff...2. Staff to accompany resident to room for needs..." Continued review revealed the RCA was a reiteration of the same information on the Incident/Accident Report.

Review of an Incident/Accident Report dated 8/15/15 and timed 4:30 AM revealed the resident had an unwitnessed fall "...Resident in activity room left in easy chair temporarily unattended (on rounds) Resident get up walked across the room and fell face first just inside the door catching

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| N 424 | Continued From page 58<br><br>herself with R arm. Skin tear on R elbow..." Continued review revealed, "...Additional comments and/or steps taken to prevent recurrence...Constant supervision when OOB [out of bed] return to bed or safe zone when unattended..." These were previous interventions on the care plan dated 7/19/15 "...Keep resident in area visible by staff when not sleeping...8/11/15 when restless keep resident in area visible by staff...8/14/15...keep resident in activity room with staff..."<br><br>Review of the RCA dated 8/19/15, for the fall on 8/15/15 at 4:30 AM revealed, "...1. Resident in activity room, staff left room, resident got out of easy chair and fell...Dementia...constant supervision..."<br><br>Review of an Incident/Accident Report dated 8/29/15 and timed 2:00 AM revealed, "...Resident got up to go the BR [bathroom] became disoriented and fell at the foot of her bed. Lying on her L side..." Continued review revealed, "...Additional comments and/or steps taken to prevent recurrence: Bed alarm doesn't work. Resident know how to disarm..." Continued review revealed the intervention of the bed alarm was not functioning and therefore did not alert staff.<br><br>Review of the RCA, not dated, revealed, "...Resident got OOB during night to use bathroom. Fell. Alarm not sounding...Dementia...Action Plan: 1. Alarm replaced...2. Keep alarm control out of resident reach..." which was a prior intervention initiated on 7/19/15.<br><br>Review of an Incident/Accident Report dated 10/2/15 revealed the resident had an unwitnessed | N 424 | | |

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| N 424 | Continued From page 59 | N 424 | | |

fall in her room "...Resident was found lying on Lt [left] side outstretched-no s/s [signs/symptoms] injuries. Res had removed her socks before fall. Resident was leaning to Lt side before fall during ambulations..." Continued review revealed, "...Additional comments and/or steps taken to prevent recurrence: Diversional activities when wandering a lot/fatigued..."

Review of the RCA for the fall on 10/2/15 and dated 10/13/15 (11 days after the fall) revealed; "...Found in room lying on floor on L side...Dementia, wandering...Action Plan...1. Diversional activity/rest when wandering a lot..."

Review of an Incident/Accident Report dated 10/5/15 and timed 6:45 PM revealed the resident had an unwitnessed fall in another resident's room "...male resident came to office said a woman was lying beside his bed on floor...resident lying on Rt side with lac [laceration] over Rt [right] eye. Ice pack applied to head-start strips applied to Rt elbow..." Interventions to keep resident in area visible by staff and constant supervision when out of bed were not in place at the time of the fall.

Medical record review of Nurse's Notes dated 10/5/16 and timed 6:45 PM revealed, "...Male resident came to nursing office stated 'there's a woman on the floor beside my bed yelling. I can't do anything for her' Res found lying on floor of [another resident's room]. Lying on Rt side blood noted at head area. ROM [Range of Motion] WNL [within normal limits]...has laceration over Rt eye-skin tear on Rt elbow et bruise on Rt wrist. Cold compress applied to head-start-strips applied to Rt elbow..."

Medical record review of a facility Transfer Form

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| N 424 | Continued From page 60 | N 424 | | |

and Documentation dated 10/5/15 revealed the resident was transferred to a local emergency room for evaluation and treatment "...Reason for transfer...found lying on floor of room...lying on Rt side with lacerations to Rt forehead over Rt eye. Laceration on Rt elbow-bruise on Rt wrist..."

Medical record review of a nurse's note dated 10/5/15 and timed 8:30 PM revealed, "...Received call from [emergency room staff]...informing resident is to return to this facility et resume orders of NH [nursing home]...states Durabond was used on laceration over Rt eye..."

Medical record review of a physician's telephone order dated 10/5/15 revealed, "...Laceration over eye-monitor daily for s/s [signs/symptoms] infection-edges approximated with Durabond..."

Review of the RCA dated 10/13/15 for the fall on 10/5/15 at 6:45 PM revealed, "...Other resident notified nurse of resident on floor in his room...Dementia, weakness, wandering...Action Plan...2. Lap buddy for positioning and safety..."

Medical record review of a nurse's note dated 10/6/15 revealed, "...Received order for lap buddy for positioning for pt safety. Pt able to remove..."

Medical record review of a Physician Telephone order dated 10/6/15 revealed, "...Lap buddy for positioning pt safety. Pt able to remove..."

Review of an Incident/Accident Report dated 10/13/15 and timed 11:40 PM revealed the resident had a fall in the activity room [unknown if witnessed or unwitnessed] "...Resident found in floor in activity [room]..." Continued review revealed, "...Additional comments and/or steps taken to prevent recurrence: Keep in area visible

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| N 424 | Continued From page 61<br><br>by staff. In chair with lap buddy when agitated/wandering..." (previous interventions that were to be in place)<br><br>Review of the RCA dated 11/3/15, for the fall on 10/13/15 (21 days after the fall) revealed, "...found on floor in activity room...Dementia, wandering...Action Plan 1. Keep in area visible by staff...2. When agitated/wandering put in w/c [wheelchair] with lap buddy and keep with staff..."<br><br>Review of an Incident/Accident Report dated 10/15/15 and timed 11:00 AM revealed, "...Pt was wandering in dining room, fell against wall. Bruise noted to back of head 2 cm [centimeters] x 1 cm tender to touch-R shoulder with redness noted-right upper arm..." Continued review revealed, "...Additional comments and/or steps taken prevent recurrence: pt placed in w/c with lap buddy...1:1 monitoring to keep pt in w/c..."<br><br>Medical record review of Nurse's Notes dated 10/15/15 and timed 11:00 AM revealed, "...Resident fell in floor in dining room hit back of head-bruising noted 2 cm x 1 cm. R [right] shoulder with red area noted..."<br><br>Medical record review of Nurse's Notes dated 10/15/15 and timed 4:45 PM revealed the resident was returned to the facility after evaluation in the emergency room with no new orders.<br><br>Review of the RCA dated 11/3/15, for the fall on 10/15/15 at 11:00 AM (19 days after the fall) revealed, "...Resident in dining room. Fell against wall...Dementia, fatigue d/t [due to] wandering...Action Plan 1. Placed in wheelchair with lap buddy...1:1 monitoring..." | N 424 | | |

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| N 424 | Continued From page 62<br><br>Interview with the DON on 1/15/15 at 11:05 AM, in the Administrator's office, revealed the DON was unable to provide any information related to how the facility initiated 1:1 monitoring. Continued interview revealed the DON did not know how the facility provided the 1:1 monitoring, what staff member was responsible for the 1:1 monitoring or for how long 1:1 monitoring occurred.<br><br>Review of an Incident/Accident Report dated 10/26/15 and timed 8:30 PM revealed, "...Res found lying on floor at foot of her bed on Rt side ROM WNL-set res up to sitting position. Lg [large] hematoma noted on Rt area above eye. Refused ice pack. Neuro [neurological] check WNL..." Continued review revealed, "...Additional comments and/or steps taken to prevent recurrence: Alarm on bed batteries changed in chair alarm..." Continued review revealed the pressure pad alarm initiated on 7/19/15 was not functioning properly.<br><br>Review of the RCA dated 11/24/15, for the fall on 10/26/15 (29 days after the fall) revealed, "...In bed. Found during rounds on floor at foot of bed. Bed alarm not sounding...Dementia...Action Plan 1. Bed alarm changed..."<br><br>Review of an Incident/Accident Report dated 11/3/15 and timed 5:00 PM revealed, "...Res found lying at foot of bed [another resident's room]-nose bleed noted-pressure applied to nose-bleeding stopped..." Continued review revealed, "...Additional comments and/or steps taken to prevent recurrence...Resident assist into w/c with lap buddy in place for safety..." This intervention had been initiated on 10/6/15.<br><br>Medical record review of Nurse's Notes dated | N 424 | | |

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| N 424 | Continued From page 63<br><br>11/3/15 and timed 6:30 PM revealed "Mobile x-ray arrived...has bruise across bridge of nose noted...8 PM received results of x-rays no fx [fracture] noted..."<br><br>Review of the RCA dated 11/24/15, for the fall on 11/3/15 (21 days after the fall) revealed, "...found in [another resident's room]...Dementia, wandering, unsteady gait..." Continued review revealed, "...Action Plan...1. In w/c with lap buddy and 1:1 for safety..."<br><br>Interview with the DON on 1/15/15 at 11:05 AM, in the Administrator's office, revealed the DON was unable to provide any information related to how the facility initiated 1:1 monitoring. Continued interview revealed the DON did not know how the facility provided the 1:1 monitoring, what staff member was responsible for the 1:1 monitoring or for how long 1:1 monitoring occurred. Further interview confirmed 1:1 monitoring was an intervention which had been in place prior to this fall as well as the intervention of constant supervision when out of bed. Further interview confirmed the resident had not been supervised as noted on the care plan.<br><br>Review of an Incident/Accident Report dated 11/6/15 and timed 7:50 AM revealed the resident had a witnessed fall in the dining room, "...Resident stood up from chair-stumbled in to window-window cracked...resident assisted by housekeeper...nurse ran to dining room to assist-no injury noted...placed in w/c with lap buddy with alarm for pt safety..." Continued review revealed, "...Additional comments and/or steps taken to prevent recurrence...pt assist to w/c with lap buddy or to bed after sedation to prevent falls..." Continued review revealed the interventions for constant supervision, or in | N 424 | | |

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wheelchair with lap buddy were not in place at the time of the fall.

Medical record review of a Physician's Telephone order dated 11/6/15 revealed, "...Order clarification: lap buddy in w/c for pt safety when pt wanders with unsteady gait and unable to be redirected. Check res [resident] q [every] 30 minutes, release lap buddy and exercise resident for 10 min [minutes] q 2 hours when lap buddy is in use..."

Review of the RCA dated 11/24/15, for the fall on 11/6/15 (18 days after the fall) revealed, "...Resident stood from chair in dining room...fell against window...Dementia, poor balance...Action Plan 1. In w/c with lap buddy...dining room seating changed. Staff to assist with ambulation..."

Review of an Incident/Accident Report dated 1/8/16 and timed 7:45 AM revealed the resident had an unwitnessed fall in another resident's room "...Called to room...per CNA. Pt found on the floor beside bed...assisted pt to w/c taken to nurses station..." Continued review revealed, "...Additional comments and/or steps taken to prevent recurrence...increase fluids to keep b/p [blood pressure] up..." Continued review revealed the interventions to keep resident visible when out of bed, constant supervision, or in wheelchair with lap buddy for protection were not in place at the time of the resident's fall.

Review of the RCA, not dated, revealed, "...CNA observed res on floor beside bed...res ambulating in room...b/p noted to be low...assisted to w/c, taken to nurses station, fluids given, blood pressure increased...Action Plan 1. Assist to w/c, taken to nurses station...fluids given for low b/p..."

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| N 424 | Continued From page 65<br><br>Observation of the resident on 1/14/16 at 12:47 PM, in the secure unit of the facility, revealed the resident up walking around unassisted, wandering in and out of rooms, and not under constant supervision or visible to staff at all times.<br><br>Observation of the resident on 1/15/16 at 8:10 AM, revealed the resident was seated in a recliner in the activities room, sleeping.<br><br>Interview with RN #1 on 1/14/16 at 11:04 AM, in the secure unit nursing station, revealed the resident did get up unassisted and ambulated unassisted. Continued interview revealed "...lap buddy did not work for her..." due to the resident being able to remove on her own and confirmed the lap buddy had not been utilized recently. Continued interview revealed the resident continued to wander unassisted.<br><br>Review of the medical record revealed the intervention of the wheelchair with the lap buddy had not been discontinued.<br><br>Interview with CNA #8 on 1/14/16 at 12:42 PM, in the secure unit, revealed "...resident just walks around..." Further interview confirmed the facility had attempted to use the lap buddy, however it was not effective and caused the resident to become more agitated. Continued interview confirmed the resident was allowed to go into her room out of the vision of staff.<br><br>Interview with the Rehab Director on 1/14/16 at 2:49 PM, in the Administrator's office, revealed the resident had significant changes in her mobility and leaning type behavior. Continued interview revealed the resident had received physical therapy services, however had since | N 424 | | |

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| BROOKEWOOD NURSING CENTER, INC | 332 RIVER ROAD DECATUR, TN 37322 |

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| N 424 | Continued From page 66 | N 424 | | |

been discharged due to the resident's cognitive status. She was now no longer able to participate in physical therapy. Continued interview revealed the Rehab Director stated "...could never say she would be safe ambulating by herself...

Interview and review of facility fall investigations and RCA reports with the DON on 1/15/15 at 11:05 AM, in the Administrator's office, confirmed the resident was assessed on admission and again in October as required the assist of one person for ambulation. Continued interview confirmed the resident was assessed as being a high risk for falls. Continued interview and review of facility fall investigations and RCA reports confirmed the DON was aware the resident had multiple falls (a total of 15 falls). Continued interview confirmed the facility had failed to ensure an effective falls prevention program was put in place to prevent future falls or injury to the resident. Continued interview confirmed the facility had failed to initiate new interventions to protect the resident from injury from falls. Further interview confirmed the current interventions which had been initiated have not been effective in preventing or reducing the number of falls.

In summary, Resident #40 had 15 falls between July 19, 2015, and January 8, 2016. There were 9 falls with no new interventions added to the Care Plan after the fall. In consideration of the lack of individualized interventions and monitoring to prevent falls, the facility failed to protect Resident #40 from falls.

The four residents reviewed each had multiple falls and each resident suffered at least one injury requiring medical intervention for falls. The facility failed to complete an RCA investigation timely after each individual fall to determine the

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| N 424 | Continued From page 87<br><br>cause for the fall and to implement an individualized appropriate intervention relevant to the cause for each fall. Review of the RCA's revealed they most often reiterated the same information from the Incident/Accident report, and were not a true root cause analysis. The facility continued to put interventions in place which had proven to be ineffective exemplified by the residents continuing to have falls with those interventions in place. The facility failed to have a system in place to ensure alarms were functioning when they were to be utilized to prevent falls, and to ensure care planned falls interventions were followed. The facility failed to implement interventions which were appropriate for residents with cognitive impairment and memory problems. | N 424 | | |
| N 601 | 1200-8-6-.06(1)(a) Basic Services<br><br>(1) Performance Improvement.<br><br>(a) The nursing home must ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization.<br><br>This Rule is not met as evidenced by:<br>Based on review of facility policies, review of facility records, medical record review, observation, interview, review of the performance improvement meetings, the PI committee failed to identify the failure to notify families of changes in condition, failed to identify care plans not being revised, failed to identify wound care not being provided for 3 (#24, #76, #77), failed to investigate injuries, failed to identify and prevent recurring falls with injury, and failed to identify | N 601 | N 601 1200-8-6-.06(1)(a) Basic Services<br>(1) Performance Improvement<br><br>3-17-16<br><br>1.The facility implemented an effective performance improvement plan facility wide. A meeting was held by the Administrator with the Medical Director present on 1/20/16 to review the 2567 along with the interdisciplinary team members consisting of: Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Business Office Manager, Dietary Supervisor, Housekeeping Supervisor, Maintenance Director, Activity Director, MDS Coordinator and the | |

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| N 601 | Continued From page 68<br>falls were not being investigated thoroughly with appropriate and individualized interventions placed. This placed Resident #23, #24, #26, #34, #40, #47, #76, in an enviornment which was detrimental to their health, safety, and welfare.<br><br>The findings included:<br><br>Interview with the Medical Director on 1/13/16, at 10:25 AM, in the Director of Nurses office, revealed the Medical Director was available on Wednesdays for any concerns of the staff stating, "I make an effort to see every resident that day..." Continued interview revealed the Medical Director was unsure of how many performance improvement Meetings he had attended in the past year or if the performance improvement team met monthly or quarterly. Interview continued and when asked if he steered the committee's work he said, "Oh no..." Interview continued and when asked how and from where information was drawn to help identify global problems the Medical Director responded, "This facility needs more resources."<br><br>Interview with the Director of Nurses (DON) on 1/15/16 at 9:32 AM, in the Administrator's office, revealed the DON had identified in October 2015 wound care treatments were not being done as ordered. Continued interview revealed the DON developed "...a plan of correction..." to address the failure to follow wound care policies. Further interview revealed the DON had completed inservices for nursing staff in October and November 2015 to re-educate nursing staff regarding wound care policies. Further interview confirmed the DON was responsible for conducting audits on treatment records to ensure wound care orders were being followed. Continued interview confirmed "...I was not aware | N 601 | Rehabilitation Manager regarding failure to notify families of changes in condition, failure to identify care plans not being revised, failure to identify wound care not being provided for 3 residents, failure to investigate injuries, failure to identify and prevent recurring falls with injury and failure to identify falls not being investigated thoroughly and with appropriate and individualized interventions. Discussed facility status as a result of the annual survey that occurred 1/10/16-1/15/16.<br><br>On 1/15/16, for resident #24, the 2 wounds were treated immediately and the procedure was documented by the Licensed Practical Nurse with the Treatment Record updated. Family was notified by the Corporate Nurse on 1/20/16.<br><br>On 1/12/16, resident #76 dressings were changed immediately by the treatment nurse and the procedure was documented on the Treatment Record.<br><br>On 1/13/16 resident #77 had wound care completed by the Licensed Practical Nurse per Medical Director order and treatment documented on the Treatment Record. The family | |

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| N 601 | Continued From page 68<br><br>falls were not being investigated thoroughly with appropriate and individualized interventions placed. This placed Resident #23, #24, #26, #34, #40, #47, #76, in an environment which was detrimental to their health, safety, and welfare.<br><br>The findings included:<br><br>Interview with the Medical Director on 1/13/16, at 10:25 AM, in the Director of Nurses office, revealed the Medical Director was available on Wednesdays for any concerns of the staff stating, "I make an effort to see every resident that day..." Continued interview revealed the Medical Director was unsure of how many performance improvement Meetings he had attended in the past year or if the performance improvement team met monthly or quarterly. Interview continued and when asked if he steered the committee's work he said, "Oh no..." Interview continued and when asked how and from where information was drawn to help identify global problems the Medical Director responded, "This facility needs more resources."<br><br>Interview with the Director of Nurses (DON) on 1/15/16 at 9:32 AM, in the Administrator's office, revealed the DON had identified in October 2015 wound care treatments were not being done as ordered. Continued interview revealed the DON developed "...a plan of correction..." to address the failure to follow wound care policies. Further interview revealed the DON had completed inservices for nursing staff in October and November 2015 to re-educate nursing staff regarding wound care policies. Further interview confirmed the DON was responsible for conducting audits on treatment records to ensure wound care orders were being followed. Continued interview confirmed "...I was not aware | N 601 | allowed only 1 more dressing change before the resident passed away on 1/17/16. The resident was on hospice care and was terminal.<br><br>For incident reporting, the Corporate Nurse completed a 100% audit. The audit revealed 34 family members had not been notified regarding incidents. A letter was sent on 1/20/2016 to any family found not to have received notification. Social Services Director also followed up with a phone call to confirm family notification had been achieved.<br><br>2. All residents have the potential to be affected by the deficient practice. Re-education was completed by the Administrator, Director of Nursing, and Assistant Director of Nursing 1/14/16-1/29/16 regarding notification of families on change of condition, care plans not being revised, wound care not being provided per physician order, failure to investigate injuries, failure to identify and prevent recurring falls with injury and failure to identify falls not being investigated thoroughly and with appropriate and individualized interventions. Re-education was | |

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| N 601 | Continued From page 68<br><br>falls were not being investigated thoroughly with appropriate and individualized interventions placed. This placed Resident #23, #24, #26, #34, #40, #47, #76, in an environment which was detrimental to their health, safety, and welfare.<br><br>The findings included:<br><br>Interview with the Medical Director on 1/13/16, at 10:25 AM, in the Director of Nurses office, revealed the Medical Director was available on Wednesdays for any concerns of the staff stating, "I make an effort to see every resident that day..." Continued interview revealed the Medical Director was unsure of how many performance improvement Meetings he had attended in the past year or if the performance improvement team met monthly or quarterly. Interview continued and when asked if he steered the committee's work he said, "Oh no..." Interview continued and when asked how and from where information was drawn to help identify global problems the Medical Director responded, "This facility needs more resources."<br><br>Interview with the Director of Nurses (DON) on 1/15/16 at 9:32 AM, in the Administrator's office, revealed the DON had identified in October 2015 wound care treatments were not being done as ordered. Continued interview revealed the DON developed "...a plan of correction..." to address the failure to follow wound care policies. Further interview revealed the DON had completed inservices for nursing staff in October and November 2015 to re-educate nursing staff regarding wound care policies. Further interview confirmed the DON was responsible for conducting audits on treatment records to ensure wound care orders were being followed. Continued interview confirmed "...I was not aware | N 601 | initiated 1/14/16 and completed 1/29/16. A Certified Nursing Assistant and a Registered Nurse returned after a leave and were in-serviced on notification of change in condition, care plans not being revised, wound care not being provided per physicians order, failure to investigate injuries, failure to identify and prevent recurring falls with injury, and failure to identify falls not being investigated thoroughly and with appropriate and individualized interventions. 2/22/2016 before taking an assignment. **Attachment #22,18,23,24,16**<br><br>The Medical Director also reviewed charts for resident #23, 24, 26, 34, 40, 47, and 76.<br><br>3. Monthly Quality Assurance Meetings are held with the Medical Director present. 100% of incident reports were audited by the Corporate Nurse on 1/20/16. Incident reports are reviewed in morning meeting for compliance with notification of family and Medical Director. The incident reports are also reviewed for appropriate and individualized interventions.<br><br>Care plans are updated reflecting current status of residents by the MDS | |

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| N601 | Continued From page 68<br><br>falls were not being investigated thoroughly with appropriate and individualized interventions placed. This placed Resident #23, #24, #26, #34, #40, #47, #76, in an enviornment which was detrimental to their health, safety, and welfare.<br><br>The findings included:<br><br>Interview with the Medical Director on 1/13/16, at 10:25 AM, in the Director of Nurses office, revealed the Medical Director was available on Wednesdays for any concerns of the staff stating, "I make an effort to see every resident that day..." Continued interview revealed the Medical Director was unsure of how many performance improvement Meetings he had attended in the past year or if the performance improvement team met monthly or quarterly. Interview continued and when asked if he steered the committee's work he said, "Oh no..." Interview continued and when asked how and from where information was drawn to help identify global problems the Medical Director responded, "This facility needs more resources."<br><br>Interview with the Director of Nurses (DON) on 1/15/16 at 9:32 AM, in the Administrator's office, revealed the DON had identified in October 2015 wound care treatments were not being done as ordered. Continued interview revealed the DON developed "...a plan of correction..." to address the failure to follow wound care policies. Further interview revealed the DON had completed inservices for nursing staff in October and November 2015 to re-educate nursing staff regarding wound care policies. Further interview confirmed the DON was responsible for conducting audits on treatment records to ensure wound care orders were being followed. Continued interview confirmed "...I was not aware | N601 | will be called to Administrator and/or Director of Nursing by nurse on affected hall to inform and seek guidance as to what further steps need to be taken to ensure safety of resident and follow facility protocol. This includes calling physician, sending out to ER, notification of responsible party, etc. Administrator/Director of Nursing will make determination at that time if further action is necessary or incident will be discussed during next scheduled morning meeting. If a responsible party is called with no response, three attempts will be made to reach the responsible party leaving a message to return the call each time.<br><br>4. Corporate nurse will be in facility weekly x 4 weeks then monthly x 3 months then quarterly. All measures will be reviewed during QA meeting monthly x 3 months then quarterly x 1 year.<br><br>The QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social | |

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| N 601 | Continued From page 69<br><br>that all of these treatments were not being done..."<br><br>Interview with the DON on 1/15/16 at 10:00 AM, in the Administrator's office, confirmed the facility's Performance Improvement committee met in January 2015 and did not meet again until September 2015. Interview continued and the DON would not comment on the 6 month interval when the work of the committee was not ongoing.<br><br>Interview with the Administrator on 1/15/15 at 1:30 PM, in her office, confirmed she assumed the Administrator's role in August 2015 and reconvened the performance improvement meetings in September. Further interview confirmed the Medical Director had been informed of the meetings, they were held on Wednesdays when he was in the facility, and she thought he "may have attended one of the four meetings...not sure..." Interview continued and, when asked how facility-wide problems were being identified and addressed, the Administrator did not answer the specific question but responded, "It is going to take time..."<br><br>Refer to N-424, N-615, N-682, and N-688 | N 601 | N615 1200-8-6-.06(2)(d)3.Basic Services<br><br>(2) Physician Services<br><br>It is the policy of this facility that the Medical Director reviews all accidents/unusual incident reports that occur at the facility, identifying hazards to health and safety and recommends corrective actions to the Administrator as issues are identified.<br><br>Resident #34 incident was self-reported on 12-28-15 by facility. On 12-24-15 Left foot/ankle assessed by nursing with no bruising, open areas or swelling was noted. X-ray was ordered and done, report stated "Small non-displaced fracture in the inferior tip of the medial malleolus. Medical Director was notified of the x-ray results and orders received for non-weight bearing until further notice and referral to orthopedist. Due to Christmas/New Years Holiday appointment was unable to be | 3/11/16 |
| N 615 | 1200-8-6-.06(2)(d)3. Basic Services<br><br>(2) Physician Services.<br><br>(d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall:<br><br>3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending | N 615 | | |

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| N 615 | Continued From page 70<br>corrective action to the administrator.<br><br>This Rule is not met as evidenced by:<br>Based on review of facility policy, review of facility documentation, medical record review, observation, and interview, the facility failed to ensure the medical Director participated in the implementation of resident care policies to investigate injuries of unknown origin and to ensure an appropriate falls intervention program was implemented to prevent residents from having multiple falls and injuries with falls. The facility's failure placed seven residents (#23, #24, #26, #34, #40, #76, and #77) in an environment detrimental to their health, safety, and welfare.<br><br>The findings included:<br><br>Review of facility policy Abuse Investigations, revised April 2010, revealed, "...All reports of resident abuse, neglect and injuries of unknown source shall promptly and thoroughly investigated by facility management...1. Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident..." Continued review of the facility abuse policy revealed, "...3. The individual conducting the investigation will, as a minimum...b. Review the resident's medical record to determine events leading up to the incident...c. Interview the person(s) reporting the incident...d. Interview any witnesses to the incident...e. Interview the resident (as medically appropriate)...g. Interview staff members (on all shifts) who have had contact with the resident | N 615 | obtained with orthopedist until January 14, 2016 @ 10:20am where resident received order for weight bearing as tolerated.<br><br>Interview on 1/23/2016 by Corporate Nurse: Resident stated she did not believe CNA did it intentionally. Sometimes resident forgets to or cannot hold foot up and foot drops. Resident states when injury occurred her foot dropped and she yelled " My foot."<br><br>Corporate Nurse asked if the CNA stopped and resident stated "yes" but not before her foot was under the wheelchair. Resident stated she did not like to have the foot rest on because she can propel herself with her feet. Resident stated she understands the need now but still doesn't like it.<br><br>1/23/2016 Corporate Nurse spoke on phone with CNA regarding her events of what happened and matched resident #34 statements. CNA stated when she started | |

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| N 615 | Continued From page 71<br>during the period of the alleged incident...h. Interview the resident's roommate, family members, and visitors...i. Interview other residents...j. Review all events leading up to the alleged incident..." Further review revealed, "...S. Witness reports should be obtained in writing. Witnesses will be required to sign and date such reports..."<br><br>Medical record review revealed Resident #34 was admitted to the facility on 6/12/14 with diagnoses including Bipolar Disorder, Diabetes Mellitus, Anxiety Disorder, Chronic Pain, Convulsions, Morbid Obesity, and Depressive Disorder.<br><br>Medical record review of the resident's care plan initiated on 2/6/15 revealed, "...the resident has an ADL [Activities of Daily Living] self-care performance deficit r/t [related to] decreased mobility, morbid obesity, bipolar disorder...Interventions/Tasks...does not ambulate...wheelchair primary mode of locomotion, propels, staff often push to destinations..."<br><br>Medical record review of a Quarterly Assessment dated 10/20/15 revealed the resident was cognitively intact. Continued review revealed the resident required extensive to total assistance with ADLs and used a wheelchair for mobility in the facility.<br><br>Review of a facility self-reported incident with occurrence date of 12/24/15 and reported date of 12/28/15 revealed Resident #34 complained of pain to her left foot and ankle on 12/24/15. Continued review of the self-reported incident revealed, "...resident has had sprain of the ankle in the past due to refusing to use the foot rest on her w/c [wheelchair]...x-ray was ordered...x-ray | N 615 | pushing resident she told resident to hold her foot up and started pushing her. CNA stated when resident said "My Foot" she stopped and placed her leg back on foot rest. She then proceeded to push resident to activity room to play bingo. States resident never complained of pain during that time.<br><br>On 1/25/16 all Nursing Staff were in-serviced on proper wheelchair propulsion by Therapy Manager. In-services continued by Therapy Manager and Assistant Director of Nursing until all staff were in-serviced. No nursing staff were allowed to return to the floor until in-service was completed.<br><br>**Attachment #25**<br><br>1/25/2016 Corporate Nurse spoke to Therapist and it was decided at that time to use Velcro straps to leg rest as an intervention in securing affected leg to leg rest to prevent leg from slipping off of | |

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| N 615 | Continued From page 72<br><br>report on 12/24/15 stated small nondisplaced fracture in the inferior tip of the medial malleolus [bonney prominence at the ankle]..."<br><br>Medical record review of a nurse's note dated 12/24/15 and timed 9:00 AM revealed, "...Resident c/o [complain of] L [left] foot/ankle pain. Rec'd [received] order for x-ray to L foot/ankle..."<br><br>Medical record review of the X-ray report dated 12/24/15 revealed, "...small nondisplaced fracture in the inferior tip of the medial malleolus..."<br><br>Medical record review of a nurse's note dated 12/24/15 and timed 12:00 PM revealed, "...Rec'd X-ray report of L foot/ankle-small nondisplaced fracture in the inferior tip of the medial malleolus. Spoke with [resident's physician], rec'd orders to make appointment with [orthopedic physician] for ortho [orthopedic] consult. Patient to be non-weight bearing until further notice..."<br><br>Interview with Resident #34 on 1/11/16 at 2:20 PM, in the Activity/Therapy Room, revealed the resident did not remember an exact date or which Certified Nurse Assistant (CNA) had been pushing the resident in her wheelchair. However the resident stated when she was being pushed, the resident believed she put her foot on the floor, her foot "...got stuck..." and the wheelchair kept going. Further interview revealed the resident believed that was the cause for the fracture to her ankle. Continued interview revealed the resident was non-weight bearing status and had an appointment with an orthopedic doctor scheduled. Continued interview confirmed no one from the facility had interviewed her related to the incident.<br><br>Interview with the Director of Nursing (DON) and | N 615 | rest. Resident understands need for the straps.<br><br>CNAs instructed not to attempt to push resident without using these straps on 1/25/2016 by Therapist and Corporate Nurse.<br><br>1/25/2016 Care plan was updated by MDS coordinator and intervention added to include: Wheelchair primary mode of locomotion, propels, staff often push to destinations. Sometimes wears strap on left foot to assist in keeping foot on foot rest. Staff were informed not to push resident in wheelchair without using foot rests and straps.<br><br>From 1/25/2016 forward there were no further injury to resident #34 as foot was being maintained safely during w/c transport and propulsion.<br><br>3/2/2016 Resident discharged to another skilled nursing facility.<br><br>Resident # 26 has positioning device currently to maintain alignment of affected hip | |

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| N 615 | Continued From page 73<br><br>Administrator on 1/14/16 at 11:11 AM, in the DON's office, revealed the DON and Administrator "...discussed..." the resident's injury in a "...morning meeting and in Risk meeting..." Further interview revealed, "...based on that discussion...assumed..." the injury was caused by the resident self-propelling herself in her wheelchair in the hallway. Continued interview revealed the resident had a similar injury in August 2015 in which the results of the facility's investigation revealed the cause of that injury was from not using foot pedals in the resident's wheelchair and the resident's foot was caught on the floor, causing a similar injury. Continued interview confirmed neither the DON, Administrator, or any other facility staff interviewed the resident or staff members regarding the injury of unknown origin. Continued interview confirmed the facility failed to conduct an investigation of the injury of unknown origin and failed to follow facility policy on investigating injuries of unknown origin.<br><br>Medical record review revealed Resident #26 was admitted on 7/29/15 with diagnoses including Dementia, Diabetes, Atrial Fibrillation, Degenerative Joint Disease and Depression.<br><br>Medical record review revealed Resident #26 was re-admitted to the facility on 9/3/15 following joint replacement surgery for a fractured left hip.<br><br>Review of the facility's 24 Hour Report/Change of Condition Report dated 9/7/15 revealed, "...Hip out of socket?"<br><br>Medical record review of the physician's telephone order dated 9/7/15 revealed, "Send to [name of hospital] for evaluation and treatment of L [left] hip." | N615 | fracture as seen by Corporate Nurse on 1/23/2016.<br><br>From 1/23/2016 forward the resident continued to be non-compliant with leaving the positioning device in place. All staff were aware to watch for this and to reinsert the positioning device as soon as it was noticed. It was observed by Director of Nursing, Assistant Director of Nursing and Therapist that device was being replaced as needed.<br><br>Restorative CNA and charge nurse were educated on proper turning and repositioning of hip fracture resident using log roll method by Therapist on 1/22/2016.<br><br>Beginning 1/22/2016 thru 2/22/2016 All nursing staff were in-serviced by Therapist and Assistant Director of Nursing on the proper log roll technique for patients with hip fractures before they were allowed to take the floor.<br><br>**Attachment #15** | |

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| N 615 | Continued From page 74<br><br>Medical record review of the hospital History and Physical dated 9/7/15 revealed, "...arrives from [nursing home] with obvious left hip dislocation...hip replacement last week for a hip fracture. This am [morning] the dayshift nursing staff apparently found her without some of her immobilizing blocks in place and with the hip pain and deformity...exact time of dislocation unknown...10:09 ED [Emergency Department] course...dAw [discussed with surgeon] he request I attempt reduction...10:54 Procedural sedation...RT [respiratory tech] at bedside...Medications employed: Versed and Propofol...Reduction of the left femur using traction, manipulation, immobilized with knee immobilizer...Post reduction film revealed normal alignment...11:01...Pt [patient] feeling 'much better'...left leg...no longer shortened..."<br><br>Interview with the DON on 1/13/16, at 10:00 AM, in the administrator's office, revealed the incident leading to Resident #26's emergency room visit on 9/7/15 was not reported on an Incident/Accident Report. The DON stated, "They [referring to the licensed nurses] know to initiate an incident report for transfers to the ER [Emergency Room]." Further interview revealed the administrative nursing staff, defined by the DON as herself, the ADON [Assistant Director of Nursing], and/or the MDS Coordinator, monitor the "24 Hour Report/Change of Condition Report" for incidents. Interview confirmed the resident's transfer to the hospital on 9/7/15 was documented on the 24 Hour Report. Interview confirmed an incident report had not been initiated by the administrative staff nurses. Interview confirmed the incident had not been investigated. | N 615 | Resident had no further injury to hip through discharge on 2/26/2016 to another SNF.<br><br>Resident #47 wound assess and dressing changed by Assistant Director of Nursing on 1/11/2016 per MD orders. Treatment to wound discontinued on 1/13/16 by treatment nurse as wound was healed.<br><br>Director of Nursing began investigation of injury of unknown origin on 1/12/2016 and incident was reported by Director of Nursing to IRS on 1/15/2016.<br><br>The staff member the Resident stated had caused the skin tear had not worked in facility since 12/23/2015.<br><br>Resident was discharged to another SNF on 2/16/2016.<br><br>Resident #24 had their 2 wounds treated immediately on | |

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| N 615 | Continued From page 75<br><br>Interview with Licensed Practical Nurse (LPN) #1 on 1/14/16 at 9:00 AM, in the administrator's office, revealed Resident #26 returned from the hospital on 9/3/15 after a left hip replacement surgery without any device to keep the proper alignment of the lower extremity. Nursing requested the rehab director to assist. She stated [name of rehab director] provided a temporary device until the ordered one came in. She stated the Certified Nurse Aides (CNA's) were verbally cautioned to maintain log rolling when turning the resident. When asked about the morning of the transfer to the hospital for the deformity of the left hip, the LPN stated the surgical area, "...did not look right, it had become swollen and red...thought it may have been out of place..." Interview revealed LPN #1 stated, "We don't usually file an incident report unless we don't know how an injury happened...in this case we thought the deformity possibly there from the beginning..." Interview confirmed there wasn't any nursing documentation of a deformity and the doctor was not notified when they suspected "something wasn't right about the hip."<br><br>Interview with the Rehab (Rehabilitation) Director on 1/14/16 at 2:45 PM, in the administrator's office, revealed Resident #26 returned to the facility after a left hip replacement without an appliance to assist with "keeping the resident from crossing the right leg over the left leg." Interview confirmed this put the left hip replacement at risk of being dislocated. The Director stated, "They allowed me to order the positioning device we needed...until it came in we tried to, in essence, create a barrier with a wedge from the physical therapy supplies and pillows to keep her from being able to cross her right leg over to her left side...the night she dislocated it didn't work..." During interview the Rehab | N 615 | 1/15/2016 by the charge nurse. The wounds were documented as being treated daily from 1/15/2016 until healed or discharged.<br><br>1/21/2016 Corporate Nurse compared the TAR to the physician's orders for accuracy. All wounds on TAR matched physician's order.<br><br>Resident #76 had their 3 wounds dressings changed immediately on 1/12/2016 by the treatment nurse and have been continued to be done daily by either the treatment nurse or floor nurse.<br><br>Resident #77 had their wound immediately treated on 1/13/2016 as per new physician's order. Family only allowed one more dressing change on 1/15/2016 before the resident passed away on 1/17/2016. | |

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| N 615 | Continued From page 76<br><br>Director confirmed there was no deformity of the left surgical hip initially and he stated, "Somehow she got her right leg over the left leg that night..."<br><br>Interview with the DON on 1/15/16 at 9:10 AM, in the Administrator's office, confirmed the facility did not complete an investigation to determine the cause of the hip dislocation.<br><br>In summary, interviews with staff revealed differing opinions on how the resident sustained the hip injury. The resident did not have the optimal positioning devices in place on return from the hospital or at the time of the injury. Physical therapy staff had attempted to put in place devices to maintain alignment until a device was received after being ordered. The facility did not complete a thorough investigation to determine what caused the injury or how the injury occurred.<br><br>Resident #47 was admitted on 1/19/2015 from the hospital with Diabetes, Parkinson's Disease, Osteoarthritis with Contracture of Hand Joints, and Deformity of Ankles and Feet.<br><br>Observation of the resident on 1/11/16 at 8:40 AM, in her room, revealed the resident lying in bed, covered up to her neck with a blanket.<br><br>Observation of Resident #47, accompanied by the ADON, on 1/11/16 at 10:00 AM, in her room, revealed a dressing applied to the left forearm dated 1/6/16.<br><br>Interview with the ADON, on 1/11/16 at 10:00 AM, in the resident's room, confirmed the area bandaged on the left forearm was a skin injury and the DON did not know how or when the skin tear occurred. | N 615 | 2) All Residents have the potential to be affected by the cited deficiency.<br><br>All residents charts were reviewed by 1/22/2016 by Corporate Nurse and no other residents with hip fractures in facility at this time.<br><br>On 1/15/2016 and 1/16/2016 Skin assessments were done on all residents by Director of Nursing/Assistant Director of Nursing. No new pressure ulcers were identified.<br><br>TARS were reviewed by the Director of Nursing and Assistant Director of Nursing on 1/15/2016 for completion of treatments as ordered; all treatments were completed as ordered.<br><br>1/21/2016 Corporate Nurse compared the TAR to the physician's orders for accuracy. All wounds on TAR matched physician's order. | |

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| N 615 | Continued From page 77<br><br>Interview with Resident #47 on 1/11/16, at 10:00 AM, revealed, "They grab my arms sometimes...when I tell it hurts they get gentle...I've told them but sometimes they forget...they take good care of me. I have a bandage on my left arm now from them moving me...the one that caused the bruise on my left arm has quit. It has not happen since. She been gone 2 weeks now..."<br><br>Interview with the DON and the ADON on 1/11/16 at 3:00 PM, in the Administrator's office, revealed the injury observed had not been investigated. The DON stated there wasn't any nursing staff member who had been terminated or left employment in the "last two weeks."<br><br>Interview with the Certified Wound Care Nurse, on 1/12/16 at 9:25 AM, in the 200 Hallway, revealed on 1/6/16, the nurse found the left forearm dressed during her weekly skin check. Interview confirmed the dressing covered a skin tear. Further interview revealed the nurse wrote an order for treatment of the skin tear, but did not report the skin tear to her supervisor or initiate an incident report. The interview confirmed skin tears on the right wrist, covered with a dressing, were found during the 12/17/15 weekly skin check and treatment was initiated. Further interview revealed the Wound Care Nurse did not report the skin tears to her supervisor or initiate an incident report.<br><br>Interview with the ADON, on 1/12/16 at 4:40 PM, in the administrator's office, confirmed an incident report was not completed and an investigation was not done for the 2 skin tears to the right wrist found on 12/17/15 by the Wound Care Nurse. Interview confirmed the skin tear to the left | N 615 | 3) 1/14/2016 All Nursing staff in-serviced by the Director of Nursing, Assistant Director of Nursing, and Administrator on how to properly complete incident reports to include actions required for injuries of unknown origin on their shift.<br><br>**Attachment#24**<br><br>3) Staff in-service was conducted by the Director of Nursing/Assistant Director of Nursing/Administrator for all nursing staff on pressure ulcers, prevention of pressure ulcers and completion of treatments as ordered. The charge nurses were informed again to check treatment records for treatments due on their shift. These in-services were completed on 2/22/2016 when RN and CNA returned from leaves. New hires will receive this in-service during orientation by Director of Nursing/Assistant Director of Nursing. | |

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| N 615 | Continued From page 78<br><br>forearm, found by the Wound Care Nurse on 12/30/15, did not have an incident report and an investigation had not been initiated. Interview confirmed the two incidents when the resident's skin was injured were injuries of unknown origin and the policy was not followed to report and investigate.<br><br>Interview with the Administrator on 1/15/16 at 11:15 AM, in the Administrator's office, confirmed the DON had not immediately initiated an investigation into Resident #47's injuries of unknown origin, even observation and interview with Resident #47 who stated a staff person caused her bruise and skin tear during care by being rough and was observed by the DON and ADON on 1/11/16.<br><br>Interview with the Medical Director on 1/13/16, at 10:25 AM, in the Director of Nurses' office, revealed the Medical Director was available on Wednesdays for any concerns of the staff stating,"I make an effort to see every resident that day..." Continued interview revealed the Medical Director was unsure of how many performance improvement meetings he had attended in the past year or if the performance improvement team met monthly or quarterly. Interview continued and when asked if he steered the committee's work he said, "Oh no...if they identify a problem they come to me..." Interview continued and the concerns related to the high number of falls for Resident #24 were shared and the Medical Director stated, "I didn't know he had that many falls."<br><br>Refer to N-424 | N 615 | In-service training on Suspected Deep Tissue injury wounds was provided by contracted Certified Wound Care Specialist on 1/25/12016 for licensed nurses.<br><br>**Attachment #23.**<br><br>On 1/22/2016 All Nurses and CNA'S were instructed on the proper techniques for turning a resident with a hip fracture using the log roll technique by the Therapist and the Assistant Director of Nursing and is on-going.<br><br>**Attachment #15**<br><br>1/25/2016 CNAs and nurses were in-serviced on proper and safe transport of residents confined to wheel chair by Therapist. Assistant Director of Nursing and Therapist will continue training on-going. | |

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| N 615 | Continued From page 78<br><br>forearm, found by the Wound Care Nurse on 12/30/15, did not have an incident report and an investigation had not been initiated. Interview confirmed the two incidents when the resident's skin was injured were injuries of unknown origin and the policy was not followed to report and investigate.<br><br>Interview with the Administrator on 1/15/16 at 11:15 AM, in the Administrator's office, confirmed the DON had not immediately initiated an investigation into Resident #47's injuries of unknown origin, even observation and interview with Resident #47 who stated a staff person caused her bruise and skin tear during care by being rough and was observed by the DON and ADON on 1/11/16.<br><br>Interview with the Medical Director on 1/13/16, at 10:25 AM, in the Director of Nurses' office, revealed the Medical Director was available on Wednesdays for any concerns of the staff stating,"I make an effort to see every resident that day..." Continued interview revealed the Medical Director was unsure of how many performance improvement meetings he had attended in the past year or if the performance improvement team met monthly or quarterly. Interview continued and when asked if he steered the committee's work he said, "Oh no...if they identify a problem they come to me..." Interview continued and the concerns related to the high number of falls for Resident #24 were shared and the Medical Director stated, "I didn't know he had that many falls."<br><br>Refer to N-424 | N 615 | **Attachment# 25**<br><br>1/23/2016 All licensed nurses were in-serviced by Director of Nursing and Assistant Director of Nursing on proper procedure for doing neuro-checks on all residents with unwitnessed falls or head injuries.<br><br>**Attachment# 26**<br><br>1/26/2016 All nursing staff were in-serviced on the proper procedure and implementation of the "Resident Intervention Log" and the "Alarms Check Logs".<br><br>**Attachment# 20, 28**<br><br>1/29/16 A follow-up in-service was initiated to Licensed Nurses to include time frame for reporting and investigation of abuse allegations by the Administrator<br><br>**Attachment#29** | |

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| | TN6101 | A. BUILDING _____ B. WING _____ | 01/15/2016 |

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| BROOKEWOOD NURSING CENTER, INC. | 332 RIVER ROAD DECATUR, TN 37322 |

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| N 615 | Continued From page 78<br><br>forearm, found by the Wound Care Nurse on 12/30/15, did not have an incident report and an investigation had not been initiated. Interview confirmed the two incidents when the resident's skin was injured were injuries of unknown origin and the policy was not followed to report and investigate.<br><br>Interview with the Administrator on 1/15/16 at 11:15 AM, in the Administrator's office, confirmed the DON had not immediately initiated an investigation into Resident #47's injuries of unknown origin, even observation and interview with Resident #47 who stated a staff person caused her bruise and skin tear during care by being rough and was observed by the DON and ADON on 1/11/16.<br><br>Interview with the Medical Director on 1/13/16, at 10:25 AM, in the Director of Nurses' office, revealed the Medical Director was available on Wednesdays for any concerns of the staff stating, "I make an effort to see every resident that day..." Continued interview revealed the Medical Director was unsure of how many performance improvement meetings he had attended in the past year or if the performance improvement team met monthly or quarterly. Interview continued and when asked if he steered the committee's work he said, "Oh no...if they identify a problem they come to me..." Interview continued and the concerns related to the high number of falls for Resident #24 were shared and the Medical Director stated, "I didn't know he had that many falls."<br><br>Refer to N-424 | N 615 | 3) Medical Director is notified of all incidents via fax for review. If significant injury occurs Medical Director or on-call Physician is notified immediately for orders.<br><br>Medical Director reviews and signs all incident reports during weekly visit to facility.<br><br>All incident reports for previous 24 hours have been and will continue to be brought to the Morning Meeting by Director of Nursing/Assistant Director of Nursing and reviewed for possible injuries of unknown origin. All injuries of unknown origin are and will continue to be investigated by Director of Nursing/Assistant Director of Nursing/ Administrator in accordance with facility abuse policy. Investigations of unknown origin are and will continue to be brought to Morning Meeting until investigation is complete. (Administrator and Director of Nursing will sign incident reports to validate completion.) | |

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| N 615 | Continued From page 78<br><br>forearm, found by the Wound Care Nurse on 12/30/15, did not have an incident report and an investigation had not been initiated. Interview confirmed the two incidents when the resident's skin was injured were injuries of unknown origin and the policy was not followed to report and investigate.<br><br>Interview with the Administrator on 1/15/16 at 11:15 AM, in the Administrator's office, confirmed the DON had not immediately initiated an investigation into Resident #47's injuries of unknown origin, even observation and interview with Resident #47 who stated a staff person caused her bruise and skin tear during care by being rough and was observed by the DON and ADON on 1/11/16.<br><br>Interview with the Medical Director on 1/13/16, at 10:25 AM, in the Director of Nurses' office, revealed the Medical Director was available on Wednesdays for any concerns of the staff stating, "I make an effort to see every resident that day..." Continued interview revealed the Medical Director was unsure of how many performance improvement meetings he had attended in the past year or if the performance improvement team met monthly or quarterly. Interview continued and when asked if he steered the committee's work he said, "Oh no...if they identify a problem they come to me..." Interview continued and the concerns related to the high number of falls for Resident #24 were shared and the Medical Director stated, "I didn't know he had that many falls."<br><br>Refer to N-424 | N 615 | On 1/15/2016, Resident skin checks were initiated by director of nursing and completed by CNAs Q Shift. Skin Observation Sheets are given to the charge nurse immediately if any change in skin condition has occurred. The Charge Nurse follows up on any changes as reported with assessment of the Resident, notification to MD for treatment as needed, and documentation. The Assistant Director of Nursing collects the Skin Check monitoring forms and brings to clinical meeting Monday-Friday for review and follow- up as needed with any change in condition for all residents.<br>**ATTACHMENT #4, #12**<br><br>Charge nurse on A Hall is responsible to ensure all monitoring forms, incident reports, and other data required is placed in Director of Nursing's box for next morning meeting. | |

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| N 615 | Continued From page 78<br><br>forearm, found by the Wound Care Nurse on 12/30/15, did not have an incident report and an investigation had not been initiated. Interview confirmed the two incidents when the resident's skin was injured were injuries of unknown origin and the policy was not followed to report and investigate.<br><br>Interview with the Administrator on 1/15/16 at 11:15 AM, in the Administrator's office, confirmed the DON had not immediately initiated an investigation into Resident #47's injuries of unknown origin, even observation and interview with Resident #47 who stated a staff person caused her bruise and skin tear during care by being rough and was observed by the DON and ADON on 1/11/16.<br><br>Interview with the Medical Director on 1/13/16, at 10:25 AM, in the Director of Nurses' office, revealed the Medical Director was available on Wednesdays for any concerns of the staff stating, "I make an effort to see every resident that day..." Continued interview revealed the Medical Director was unsure of how many performance improvement meetings he had attended in the past year or if the performance improvement team met monthly or quarterly. Interview continued and when asked if he steered the committee's work he said, "Oh no...if they identify a problem they come to me..." Interview continued and the concerns related to the high number of falls for Resident #24 were shared and the Medical Director stated, "I didn't know he had that many falls."<br><br>Refer to N-424 | N 615 | During off hours and weekends regardless of shift any incident resulting in injury, abuse or suspected abuse or injury of unknown origin will be called to the Director of Nursing and/or Administrator for immediate action. Incidents that are serious in nature requiring a visit to ER will be immediately called to the MD for orders to transport.<br><br>Nurses are instructed in case DON/Administrator/MD can not be reached to initiate 911 call then continue to try to contact above. Incident reports not resulting in actual harm will be completed and turned in to the Director of Nursing during next scheduled clinical meeting. All nurses in serviced on the fall procedure and posted at Nurses Station.<br><br>**Attachment# 5,16** | |

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| N 615 | Continued From page 78<br><br>forearm, found by the Wound Care Nurse on 12/30/15, did not have an incident report and an investigation had not been initiated. Interview confirmed the two incidents when the resident's skin was injured were injuries of unknown origin and the policy was not followed to report and investigate.<br><br>Interview with the Administrator on 1/15/16 at 11:15 AM, in the Administrator's office, confirmed the DON had not immediately initiated an investigation into Resident #47's injuries of unknown origin, even observation and interview with Resident #47 who stated a staff person caused her bruise and skin tear during care by being rough and was observed by the DON and ADON on 1/11/16.<br><br>Interview with the Medical Director on 1/13/16, at 10:25 AM, in the Director of Nurses' office, revealed the Medical Director was available on Wednesdays for any concerns of the staff stating,"I make an effort to see every resident that day..." Continued interview revealed the Medical Director was unsure of how many performance improvement meetings he had attended in the past year or if the performance improvement team met monthly or quarterly. Interview continued and when asked if he steered the committee's work he said, "Oh no...if they identify a problem they come to me..." Interview continued and the concerns related to the high number of falls for Resident #24 were shared and the Medical Director stated, "I didn't know he had that many falls."<br><br>Refer to N-424 | N 615 | All incidents of serious nature to include falls with injury, abuse allegations, etc. will be called to Administrator and/or Director of Nursing by nurse on affected hall to inform and seek guidance as to what further steps need to be taken to ensure safety of resident and follow facility protocol. This includes calling physician, sending out to ER, notification of responsible party, etc. Administrator/Director of Nursing will make determination at that time if further action is necessary or incident will be discussed during next scheduled morning meeting. If a responsible party is called with no response, three attempts will be made to reach the responsible party leaving a message to return the call each time. | |

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| N 615 | Continued From page 78<br><br>forearm, found by the Wound Care Nurse on 12/30/15, did not have an incident report and an investigation had not been initiated. Interview confirmed the two incidents when the resident's skin was injured were injuries of unknown origin and the policy was not followed to report and investigate.<br><br>Interview with the Administrator on 1/15/16 at 11:15 AM, in the Administrator's office, confirmed the DON had not immediately initiated an investigation into Resident #47's injuries of unknown origin, even observation and interview with Resident #47 who stated a staff person caused her bruise and skin tear during care by being rough and was observed by the DON and ADON on 1/11/16.<br><br>Interview with the Medical Director on 1/13/16, at 10:25 AM, in the Director of Nurses' office, revealed the Medical Director was available on Wednesdays for any concerns of the staff stating,"I make an effort to see every resident that day..." Continued interview revealed the Medical Director was unsure of how many performance improvement meetings he had attended in the past year or if the performance improvement team met monthly or quarterly. Interview continued and when asked if he steered the committee's work he said, "Oh no...if they identify a problem they come to me..." Interview continued and the concerns related to the high number of falls for Resident #24 were shared and the Medical Director stated, "I didn't know he had that many falls."<br><br>Refer to N-424 | N 615 | 4) Corporate nurse will be in facility weekly x 4 weeks then monthly x 3 months.<br><br>Results of monitoring will be reviewed in Quality Assurance weekly for one month, and then monthly times two or until substantial compliance is met.<br><br>The Quality Assurance committee consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Nurse, Social Services, Business Office Manager, Dietary Supervisor, Housekeeping Director, Maintenance Director, Activity Director, and Rehabilitation Services Director. | |

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| N 682 | Continued From page 79<br>N 682 1200-8-6-.06(4)(f) Basic Services<br><br>(4) Nursing Services.<br><br>(f) The facility must ensure that an appropriate individualized plan of care is prepared for each resident with input from appropriate disciplines, the resident and/or the resident ' s family or the resident ' s representative.<br><br>This Rule is not met as evidenced by:<br>Based on review of facility policy, medical record review, review of facility documentation, interview, and observation, the facility failed to revise the Care Plan for 4 residents (#24, #40, #23, #26) with falls of 8 sampled residents of 20 residents with repeated falls, and failed to revise the Care Plan for 2 residents (#76, #24) with pressure ulcers of 3 residents reviewed for pressure ulcers, of 32 sampled residents. The facility's failure to revise the Care Plan for residents with falls resulted in injury to the residents and Placed residents #24, #40, #23, and #26, in an enviornment detrimental to their health, safety, and wefare. The facility's failure to revise the Care Plan for treatment of Pressure Ulcers Placed residents #76 and #24 in an enviornment detrimental to their health, safety, and wefare. The facility's failure is likely to place any resident at risk for falls and Pressure Ulcers in an enviornment detrimental to their health, safety, and welfare.<br><br>The findings included:<br><br>Review of the facility policy Falls, Post-Fall Protocol, effective 8/2012, revealed, "...The MDS [Minimum Data Set] Coordinator or Director of Nursing will...c. Add new interventions to the | N 682<br>N 682 | N682 1200-8-6-.06(4)(f) Basic Services<br><br>(4) Nursing Services<br><br>The facility ensures that an appropriate individualized plan of care is prepared for each resident with input from appropriate disciplines, the resident and/or resident's family or the resident's representative.<br><br>1. The Care Plan for Resident #24 was reviewed by the Corporate Nurse and updated with the assessment from the most recent comprehensive MDS and CAAs on 1/22/2016. The Care Plan was reviewed for accuracy with current Resident status to include fall risk, falls, and current interventions to address fall risk; and to include the development of pressure ulcers and the current | 3-17-16 |

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| N 682 | Continued From page 80<br>resident's fall risk care plan..."<br><br>Medical record review revealed Resident #24 was admitted to the facility on 8/20/10 with diagnoses including Alcoholic Cirrohsis of the Liver, Chronic Airway Obstruction, Dementia with Behavioral Disturbance, Depressive Disorder, Diabetes Mellitus, and Chronic Persistence Hepatitis and readmitted to the facility on 7/10/15 with diagnoses of Aftercare for Healing Traumatic Fracture of the Hip and Difficulty Walking.<br><br>Medical record review of the resident's fall care plan, initiated 12/26/14 revealed, "...The resident is at risk for fall r/t [related to] easily fatigued, history of falls, weakness..."<br><br>Medical record review of the resident's fall care plan initiated 12/26/2014 revealed the resident's care plan was updated to reflect 18 dates the resident had falls: 1/31/15, 2/8/15, 2/15/15, 2/19/15, 3/12/15, 3/23/15, 4/4/15, 4/11/15, 4/22/15, 4/30/15, 5/14/15, 5/20/15, 6/14/15, 6/22/15, 6/27/15, 6/30/15, 7/5/15 and 7/12/15. Continued review of the resident's care plan revealed the only times the resident's care plan was revised to reflect a new intervention after a fall was "...2/19/15 Eval [evaluate] got room change-closer to N.S. [nurse station]..."; 3/23/15 "...Res [resident] to keep urinal in easy reach..."; and 4/4/15 "...Abt [antibiotic] for UTI [urinary tract infection]..."<br><br>Review of facility documentation revealed the resident had a total of 8 falls between 7/30/15 and 8/31/15.<br><br>Medical record review of the resident's fall care plan initiated 7/30/15 revealed the resident's care plan was updated to reflect the resident had 8 | N 682 | treatment for the pressure areas on 1/22/2016. A Fall Risk Assessment was completed for this Resident on 1/17/2016 by the Director of Nursing. The Braden Scale Assessment completed by the MDS Coordinator on 12/1/2015 was reviewed by the Assistant Director of Nursing on 1/17/2016 and updated to reflect the correct scoring for the Resident.<br><br>The Care Plan for Resident #40 was reviewed by the Corporate Nurse and updated with the assessment from the most recent comprehensive MDS and CAAs on 1/2/2016. The Care Plan was reviewed for accuracy with current Resident status to include fall risk, falls, and current interventions to address fall risk on 1/22/2016. A Fall | |

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| N 682 | Continued From page 61<br><br>falls: 8/2/15, 8/8/15, 8/10/15, 8/14/15, 8/20/15, 8/27/15 (2 falls), and 8/31/15. Continued review of the resident's care plan revealed the only times the resident's care plan was revised to reflect a new intervention after a fall was "...8/20/15 More frequent checks for needs..."<br><br>Interview with the Director of Nursing (DON) on 1/13/16, at 11:10 AM, in the Administrator's office, revealed the DON was unable to provide information on how the intervention of "...more frequent checks..." was implemented.<br><br>Review of facility documentation revealed the resident had a total of 13 falls between 9/16/15 and 10/30/15.<br><br>Medical record review of the resident's fall care plan initiated 9/16/15 revealed the resident's care plan was updated to reflect the resident had 13 falls: 9/21/15, 9/22/15, 9/24/15, 9/26/15, 9/27/15 (2 falls), 10/1/15, 10/2/15 (2 falls), 10/5/15, 10/7/15, 10/9/15, and 10/16/15. Continued review of the resident's care plan revealed the care plan was not revised to reflect any new interventions to address the resident's falls during this time period.<br><br>Review of facility documentation revealed the resident had a total of 6 falls between 10/30/15 and 1/5/16.<br><br>Medical record review of the resident's fall care plan initiated 10/20/15 revealed the resident's care plan was updated to reflect the resident had 6 falls: 11/19/15 (2 falls), 11/25/15, 12/2/15, 12/13/15, and 1/5/16. Continued review of the resident's care plan revealed the care plan was not revised to reflect any new interventions to address the resident's falls except on 11/19/15 | N 682 | Risk Assessment was completed for Resident #40 on 1/17/2016 by the 6am-2pm Charge Nurse.<br><br>The Care Plan for Resident #23 was reviewed by the Corporate Nurse and updated to reflect the most current comprehensive MDS and CAAs on 1/22/2016. The Care Plan was reviewed for accuracy with current Resident status to include fall risk, falls, and current interventions to address fall risk on 1/22/2016. A Fall Risk Assessment was completed for Resident #23 on 1/17/2016 by the Assistant Director of Nursing.<br><br>The Care Plan for Resident #26 was reviewed by the Corporate Nurse and | |

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| N 682 | Continued From page 82<br>(10:00 PM) "...Therapy to evaluate and change w/c [wheel chair] cushion..."<br><br>Interview with the Director of Nursing on 1/13/16 at 11:10 AM, in the Administrator's office, confirmed the resident's care plan was not revised to reflect new or effective interventions to address the resident's continued falls.<br><br>In summary, Resident #24 had 46 falls between January 31, 2015, and January 5, 2016. There were 32 falls with no new interventions added to the Care Plan after the fall. Ineffective and repetitive interventions, for example, "Be sure the resident's call light is in reach and encourage to use it for assistance as needed..." and "...Reminded resident not to turn off alarm..." were used repetitively for 29 falls. In consideration of the lack of individualized interventions and monitoring to prevent falls, the facility failed to protect Resident #24 from falls.<br><br>Resident #40 was admitted to the facility on 7/17/15 with diagnoses including Senile Dementia with delusional features, Difficulty in Walking, Depressive Disorder, Diabetes Mellitus, Hypertension, and Insomnia.<br><br>Medical record review of the resident's fall care plan, initiated 7/29/15, revealed, "...The resident is at risk for fall r/t [related to] history of falls, decreased mobility, use of psychotropic medication...7/10/15 fall no injury..."<br><br>Review of facility documentation revealed the resident had a total of 15 falls between 7/29/15 and 1/8/16.<br><br>Medical record review of the resident's fall care | N 682 | updated to reflect the most recent comprehensive MDS and CAAs on 1/22/2016. The Care Plan was reviewed for accuracy with the Resident's current status to include fall risk, falls, and current interventions to address fall risk by the Corporate Nurse on 1/22/2016. A Fall Risk Assessment was completed for Resident #26 on 1/17/2016 by the Director of Nursing.<br><br>The Care Plan for Resident # 76 was reviewed by the Corporate Nurse and updated to reflect the most recent comprehensive MDS and CAAs on 1/22/2016. The Care Plan was reviewed for accuracy with the Resident's current status to include Pressure Ulcer Risk, current Pressure Ulcers, current treatments orders | |

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| N 682 | Continued From page 83<br>plan, initiated 7/29/15 revealed the resident's care plan was updated to reflect the resident had 15 falls. 6/7/15, 8/11/15, 8/13/15, 8/14/15 (2 falls), 8/15/15, 8/29/15, 10/2/15, 10/5/15, 10/13/15, 10/15/15, 10/26/15, 11/3/15, 11/6/15, and 1/8/16. Continued review revealed the resident's care plan was revised to reflect new interventions after 8/7/15 only 6 of the 15 falls. "...freq [frequent] rest periods prn [as needed]; 8/13 "...keep seated on toilet until floor cleaned of spills..."; 10/2/15 "...diversional activity when wandering a lot/fatigued..."; 10/6/15 "...lap buddy for positioning and pt safety. Pt able to remove..."; 11/6/15 "...dining room seating changed..." 1/8/16 "...assist to w/c, in nurses station, given fluids for low b/p [blood pressure]..."<br><br>Interview with the DON on 1/15/16 at 10:55 AM, in the Administrator's office, confirmed the resident's fall care plan was not revised to reflect new or effective interventions to address the resident's continued falls.<br><br>In summary, Resident #40 had 15 falls between July 19, 2015, and January 8, 2016. There were 9 falls with no new interventions added to the Care Plan after the fall. In consideration of the lack of individualized interventions and monitoring to prevent falls, the facility failed to protect Resident #40 from falls.<br><br>Medical record review revealed Resident #23 was re-admitted to the facility from the hospital on 1/19/15 with diagnoses including Recent History of Pneumonia, Alzheimer's Dementia, Parkinson's Disease, Type 2 Diabetes, and Cerebral Vascular Disease.<br><br>Review of facility documentation revealed the | N 682 | and interventions due to pressure ulcers/risk on 1/22/2016. A Doppler study was ordered and completed on 2/1/2016 due to edema and wounds of bilateral lower extremities.<br><br>2. Because all Residents with fall risk and risk for development of pressure ulcers could potentially be affected by the cited deficiency:<br><br>Care Plans for all Residents with pressure ulcers and falls were reviewed and updated by the MDS Nurse, competed on 1/27/2016.<br><br>Care Plans for all other Residents were reviewed and updated by the Interdisciplinary Team, consisting of the MDS Nurse, Social Services Director, Dietary Manager, | |

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| N 882 | Continued From page 84<br>resident had 8 falls between 4/23/15 and 12/21/15: 4/23/15; 5/17/15; 5/24/15; 5/25/15; 5/27/15; 6/1/15; 11/22/15; and 12/21/15.<br><br>Medical record review of the resident's fall care plan, initiated 12/03/14 and continued at re-admission on 1/19/15, last updated 11/22/15 revealed "...at risk for falls ..." Review continued and revealed the interventions for the high risk of falls included: Anticipate and meet the resident's needs; Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed; The resident needs prompt responses to all requests for assistance; Ensure that the resident is wearing appropriate footwear; Falls risk assessment quarterly, with significant change, and prn [as needed]; Follow facility fall protocol; Keep items of frequent use within resident reach; PT [physical therapy] evaluate and treat as ordered or PRN [as needed]. Continued review revealed the care plan had been updated to reflect the resident had 7 falls: 4/23/15; 5/17/15; 5/24/15; 5/27/15; 6/1/15; 11/22/15; and 12/21/15.<br><br>Medical record review of the fall Care Plan revealed no new interventions after the falls on 4/23/15, 5/24/15, 5/25/15, and 12/21/15.<br><br>Medical record review review revealed the Care Plan had been updated after the fall 5/17/15 with the intervention of a bed alarm.<br><br>Medical record review revealed the Care Plan had been updated after the fall 5/27/15 with the intervention of "redirect and reorient" and restated the previous intervention of "encourage the resident to use the call light as needed".<br><br>Medical record review revealed the Care Plan | N 882 | Activities Director and were completed on 1/31/2016.<br><br>3. All Resident Care Plans are brought to the morning Clinical Meeting, Monday-Friday and updated as indicated by review of Physician Orders, Incident Reports, and 24 Hour Nursing Reports; this review and updating process began on 1/31/2016 and will continue.<br><br>The MDS Nurse was educated on the importance of detailed notes when discussing falls and having new interventions or referrals as indicated with each fall (when possible) by the Corporate Nurse on 1/26/2016. | |

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| N 682 | Continued From page 85<br>had been updated after the fall 6/01/15 with the intervention of "remind resident prn not to sit on edge of w/c seat".<br><br>Medical record review revealed the Care Plan had been updated after the fall 11/22/15 with the intervention of "reality orientation".<br><br>Interview with the DON on 1/15/16 at 10:05 AM, in the administrator's office, confirmed, after the fall on 4/23/15 no new interventions were put into place. Further interview confirmed the plan of care did not include an effective intervention to assist in fall prevention except the 5/17/15 fall with the use of a bed alarm and, after the next 6 falls, the interventions were a repeated intervention or not an effective intervention due to the resident's impaired cognitive status. Interview continued and confirmed the resident's fall of 12/21/15 resulted in a head injury, the resident's pressure pad had already been in use in her wheel chair prior to the 12/21/15 fall and maintaining the proper functioning of the alarm was not a new intervention.<br><br>In summary, Resident #23 had 8 falls between April 23, 2015, and December 21, 2015. There were 7 falls with no new interventions added to the Care Plan after the fall. In consideration of the lack of individualized interventions and monitoring to prevent falls, the facility failed to protect Resident #23 from falls.<br><br>Medical record review revealed Resident #26 was admitted to the facility on 7/29/15, with diagnoses including Degenerative Joint Disease, Dementia with Behaviors, Depression, and Type II Diabetes.<br><br>Medical record review of Resident #26's fall care | N 682 | All fall and pressure ulcer care plans will be reviewed at the time of the incident and updated during the morning clinical meeting. The MDS nurse will immediately update the case plans with appropriate intervention(s). The DON or if DON not available the nurse in attendance will counter sign to ensure interventions were added. This process of having two nurse signatures will continue with each fall and pressure ulcer care plan until the Administrator/DON is satisfied that no interventions are being missed or are inappropriate. This process will begin 1/27/2016.<br><br>4. Results of the Care Plan monitoring will be reviewed in Quality Assurance weekly for one month and then monthly times two or until substantial compliance is met. The QA Committee consist of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, MDS Nurse, Social Services, Business Office Manager, Dietary Supervisor, Housekeeping Director, Maintenance Director, Activity Director | |

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| N 682 | Continued From page 86<br><br>plan dated 8/7/15 revealed "...The resident is at risk for fall..." Continued review revealed interventions included "...Anticipate and meet the resident's needs...Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed... Ensure that the resident is wearing appropriate footwear.... Follow facility fall protocol. Keep items of frequent use within resident reach. PT [Physical Therapy] evaluates and treats as ordered or PRN [as needed]..."<br><br>Medical record review revealed the resident had 5 falls between 8/28/15 and 12/25/15, on 8/28/15, 10/13/15, (2) on 11/28/15, and 12/25/15.<br><br>Medical record review of the care plan dated 8/7/15 revealed the care plan was updated with new interventions for the falls on 10/13/15 and 11/28/15.<br><br>Medical record review of the care plan dated 8/7/15 revealed no additional interventions for falls prevention after the 8/28/15 fall with fracture nor after the 12/25/15 fall with fracture.<br><br>Medical record review of the care plan revealed on 10/13/15 the intervention for the fall on that date "pressure pad alarm to bed & [and] wheelchair".<br><br>Medical record review of the care plan revealed on 11/28/15 the interventions for the two falls on that date were "Toilet resident and put down for a nap ...To ER for eval and Tx ...Encourage to call for assistance with transfer (a repeat of a previous intervention).<br><br>Medical record review of the Care Plan dated 8/7/15, updated on 12/26/15, revealed | N 682 | and Rehabilitation Services Director.<br><br>Corporate Nurse will be in facility weekly for four weeks and then monthly for 3 months. | |

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| N 882 | Continued From page 87<br><br>interventions of "to ER for eval and tx" and "...Alarm replaced..."<br><br>Interview with the DON on 1/13/16 at 10:53 AM, in the Administrator's office revealed a new intervention put in place after the 8/28/15 and 12/25/15 falls with fracture was to send Resident #26 "to ER for eval and tx". Continued interview with the DON confirmed that was not an intervention for falls prevention and confirmed no new interventions were put in place when Resident #26 came back to the facility from the hospital after the 8/28/15 fall. Continued interview revealed "...The prior intervention of wheel chair alarm on 12/25/15 was ineffective if it was not working per staff..."<br><br>In summary, Resident #26 had 5 falls between August 28, 2015, and December 25, 201. There were 2 falls with no new interventions added to the Care Plan after the fall; ineffective interventions, for example: "to ER [emergency room] for eval and Tx [evaluation and treatment], and "Alarm replaced". In consideration of the lack of individualized interventions and monitoring to prevent falls, the facility failed to protect Resident #26 from falls.<br><br>Medical record review revealed Resident #76 was admitted to the facility on 12/18/15 with diagnoses including Encounter for Aftercare, Difficulty Walking, Malignant Neoplasm of Vertebral Column, Hemiplegia and Hemiparesis, and Diabetes Mellitus type 2.<br><br>Review of facility policy Pressure Ulcer Prevention, effective 9/2012, revealed, "...Resident Plan of Care...2. The Plan of Care should address risk factors, intervention measures, nutrition, hydration, incontinence, skin | N 882 | | |

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| N 682 | Continued From page 88<br><br>care, mobility needs, pressure reduction, turning and positioning schedule, and treatment orders. The care plan will be reviewed and updated as needed to accurately address the resident's needs. 3. The Plan of Care is to be updated with change in status of the resident, with changes in wounds, and with treatment order changes. The Plan of Care is to be current at all times..."<br><br>Medical record review of Interim Care plan dated 12/18/15 revealed, "...unstageable sacral [coccyx] wound...R [right] heel deep tissue injury..."<br><br>Medical record review of the resident's care plan, not dated, revealed, "...The resident has pressure ulcer, unstageable on coccyx, deep tissue injury to right heel..." Continued review revealed, "...Interventions/tasks...administer treatments as ordered and monitor for effectiveness..."<br><br>Medical record review of the Weekly Pressure Ulcer Record dated 12/30/15 revealed the resident had developed a Suspected Deep Tissue Injury (SDTI) to the left lateral heel.<br><br>Medical record review of nurse's wound care note dated 12/31/15 revealed, "...Weekly skin assessment done. Resident has new SDTI present to L [left] lateral heel. Current tx [treatment] continues to R lateral heel SDTI..."<br><br>Medical record review of the resident's Plan of Care not dated revealed the care plan was not revised to the reflect the development of the SDTI to the left lateral heel or treatment orders.<br><br>Interview with the Director of Nursing (DON) on 1/15/16 at 1:21 PM, in the DON's office, confirmed Resident #76's care plan was not revised to reflect the development of the SDTI to | N 682 | | |

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| N 682 | Continued From page 89<br>the left lateral heel.<br><br>Resident #24 was admitted to the facility on 8/20/10 on 7/10/15 with diagnoses including Alcoholic Cirrhosis of the Liver, Chronic Airway Obstruction, Dementia with Behavioral Disturbance, Depressive Disorder, Diabetes Mellitus, and Chronic Persistence Hepatitis and readmitted to the facility on 7/10/15 with diagnoses of Aftercare for Healing Traumatic Fracture of the Hip and Difficulty Walking.<br><br>Medical record review of the resident's care plan initiated 10/30/15 revealed, "...the resident has potential for impairment to skin integrity of the r/t (related to) fragile skin..." Continued review revealed, "...Interventions/Tasks...treatments as ordered..."<br><br>Medical record review of the Wound Care Nurse note dated 12/30/15 revealed, "...Weekly skin assessment done. 2 new SDTI to R lateral heel and to R lateral foot..."<br><br>Medical record review of a Physician's Telephone order dated 12/31/15 revealed physician's orders for the treatment of the SDTI "...12/31/15 1. Apply skin prep and dry padded dsg [dressing] to R heel SDTI as protection (change Mon [Monday], Wed [Wednesday], Friday) 2. Apply skin prep and dry padded dsg to R lateral foot SDTI as protection (change Mon, Wed, Friday)...3. Keep feet elevated as resident will allow with pillows..."<br><br>Medical record review revealed the residents care plan was not updated to reflect the development of the new pressure ulcers and the care plan did not reflect the current treatment for the pressure areas. | N 682 | | |

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| N 682 | Continued From page 90<br><br>Interview with the DON on 1/15/16 at 9:32 AM, in the Administrator's office, revealed the MDS Nurse was "...responsible..." for updating a resident's care plan with the development of any new pressure areas or changes in wound status. Continued interview revealed the MDS (Minimum Data Set) Nurse was also responsible for updating the resident's care plan with any new wound care orders. Further interview with the DON confirmed the resident's care plan had not been revised to reflect the development of the SDTI to the resident's right heel and right lateral foot.<br><br>N 686 1200-8-6-.06(4)(l) Basic Services<br><br>(4) Nursing Services<br><br>(l) Each resident shall be given proper personal attention and care of skin, feet, nails and oral hygiene in addition to the specific professional nursing care as ordered by the resident's physician.<br><br>This Rule is not met as evidenced by:<br>Based on review of facility policy, medical record review, observation and interview, the facility failed to provide wound care for pressure ulcers as ordered for 3 residents (#76, #24, #77) of 3 residents reviewed for pressure ulcers. The facility's systematic failure to provide wound care as ordered placed the residents in an environment detrimental to their health, safety, and welfare.<br><br>The findings included: | N 682<br><br>N 686 | N688 1200-8-6-.06(4)(l) Basic Services<br><br>(4) Nursing Services<br><br>The facility provides each Resident with proper personal attention and care of skin, feet, nails and oral hygiene in addition to the specific professional nursing care as ordered by the Resident's physician.<br><br>1. Resident #76 had their 3 wound dressings changed immediately on 1/12/2016 by the treatment nurse and have been continued to be done as ordered by physician by either the treatment nurse or licensed nurse. On 1/21/2016 the Corporate Nurse compared the TAR to the physician's orders for accuracy. All wounds on TAR matched physician's order. Resident #76 discharged on | 3-17-16 |

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| N 668 | Continued From page 91<br><br>Review of facility policy Pressure Ulcers, effective 9/2012 revealed, "...3. The facility will ensure that all residents at risk for pressure ulcers are identified to be at risk and given care to prevent the development of pressure ulcers...4. The facility will ensure that a resident with pressure ulcers receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing...5. The Charge Nurse and Treatment Nurse will...b. Provide wound care as prescribed by the physician...ii. Document in the Treatment Administration Record (TAR) that wound care was administered as prescribed..."<br><br>Medical record review revealed Resident #76 was admitted to the facility on 12/18/15 with diagnoses including Encounter for Aftercare, Difficulty Walking, Malignant Neoplasm of Vertebral Column, Hemiplegia and Hemiparesis, and Diabetes Mellitus type 2.<br><br>Medical record review of the Resident-Data Collection Admission assessment dated 12/18/15 revealed, "...General Skin Condition...dry...warm...Skin Condition...black areas on outer side of both heels...skin dry..." Continued review revealed no documentation the resident had a pressure ulcer.<br><br>Medical record review of an Interim Care plan dated 12/18/15 revealed, "...unstageable sacral wound...R [right] heel deep tissue injury..." and no documentation regarding the left heel, which was black to the outer side according to the Resident -Data Collection Assessment.<br><br>Medical record review of the resident's care plan, not dated, revealed, "...The resident has pressure | N 668 | 2/13/2016 to home.<br><br>Resident #24 had their 2 wounds treated immediately on 1/15/2016 by the charge nurse. The wounds were documented as being treated daily from 1/15/2016.<br>On 1/21/2016, the Corporate Nurse compared the TAR to the physician's orders for accuracy.<br><br>All wounds on TAR matched physician's order.<br>Resident #24 discharged on 1/24/2016 to Geri-Psych.<br><br>Wound Care was provided as ordered for Resident #77 on 1/13/2016, and on 1/15/2016. The Resident's dressings were assessed on 1/14/2016 by the Treatment Nurse and on 1/16/2016 by the Director of Nursing, but were not changed on these dates at the family's request for comfort measures for the Resident. | |

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| N 668 | Continued From page 92<br>ulcer; unstageable on coccyx [sacral]; deep tissue injury to right heel..." Continued review revealed, "...interventions/tasks...administer treatments as ordered and monitor for effectiveness..."<br><br>Medical record review of a Braden Scale For Predicting Pressure Sore Risk dated 12/18/15 revealed the resident scored 18 indicating the resident was at "...Mild risk: total score 15-18..." of developing a pressure ulcer.<br><br>Medical record review of a Physician telephone order dated 12/23/15 revealed, "...1. Cleanse sacral unstageable wound with wc/ns [wound cleaner/normal saline]. Apply skin prep to periwound. Apply santyl to wound bed, pack with calcium alginate, and cover with dry padded dsg [dressing]. Change daily at [and] prn [as needed] for dsg saturation or removal...2. Apply skin prep and dry dsg to SDTI [suspected deep tissue injury] to R lateral heel change 3x [times] wk [week] (Mon [Monday], Wed [Wednesday], Friday) at prn..."<br><br>Medical record review of the Treatment Record (TAR) for December 2015 revealed the resident's sacral wound was not treated on 12/25/15 or 12/27/15. Continued review revealed no documentation the resident's right lateral heel wound care was completed on 12/25/15 or 12/26/15.<br><br>Medical record review of a nurse's wound care note dated 12/23/15 revealed, "...Weekly skin assessment done...sacral wound is unstageable...SDTI noted to R lateral heel. Area is dry, purple hue present...[no] other areas to note..." Continued review revealed no documentation regarding the left heel which was black to the outer side according to the | N 668 | This Resident was on Hospice Care and passed away on 1/17/2016.<br><br>2. All Residents have the potential to be affected by the cited deficiency.<br><br>A Skin Assessment was done on all Residents in the facility by the Director of Nursing and Assistant Director of Nursing on 1/15/2016 and 1/16/2016; no new pressure ulcers were identified.<br><br>Treatment Records were reviewed by the Director of Nursing and Assistant Director of Nursing on 1/15/2016 for completion of treatments as ordered; all treatments were completed as ordered.<br>**Attachments #4,10,11,12**<br><br>3. Staff In-service training on Pressure Ulcers, Pressure Ulcer Prevention, completion of Treatments as ordered, and | |

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| N 688 | Continued From page 93<br>Resident Data Collection Assessment.<br><br>Medical record review of a Weekly Pressure Ulcer Record dated 12/30/15 revealed the resident had developed a SDTI to the left lateral heel. Continued review revealed the SDTI to the left lateral heel was documented as measuring 3 centimeters [cm] by 3 cm.<br><br>Medical record review of a nurse's wound care note dated 12/31/15 revealed, "...Weekly skin assessment done. Resident has new SDTI present to L lateral heel. Current tx [treatment] continues to R lateral heel SDTI..."<br><br>Medical record review of the TAR for December 2015 revealed a new wound care order 12/30/15 for the development of the SDTI to the left lateral heel "...Apply skin prep and dry dsg to SDTI to L (left) lateral heel change 3x wk (Mon, Wed, Friday)..."<br><br>Medical record review of the TAR for January 2016 revealed the resident's sacral wound care was not completed on 1/2/16, 1/3/16, 1/5/16, 1/8/16, 1/9/16, 1/10/16, and 1/11/16. Continued review revealed wound care was not completed on the resident's right lateral heel on 1/8/16 and 1/11/16. Further review revealed the treatment order for the resident's left heel wound was not placed on the January 2016 TAR and wound care was not completed to the SDTI until a new order was received on 1/6/16.<br><br>Medical record review of a Weekly Pressure Ulcer Record dated 1/6/16 revealed the wound to the left lateral heel was now presenting as a Stage 3 pressure ulcer measuring 3 cm x 5.5 cm. Continued review of a Weekly Pressure Ulcer record dated 1/12/15 revealed the wound was | N 688 | review of facility Policies was initiated on 1/14/2016 by the Director of Nursing and was completed for all staff on 1/26/2016.<br><br>In-service training on Suspected Deep Tissue injury wounds was provided by contracted Certified Wound Care Specialist on 1/25/12016 for licensed nurses.<br><br>In-services were conducted on 2/22/2016 one RN and one CNA new hire. New hires will receive this in-service during orientation by Director of Nursing/Assistant Director of Nursing.<br>**Attachment #23**<br><br>On 1/15/2016, Resident skin checks were initiated and completed by CNAs Q Shift. Skin Observation Sheets are given to the charge nurse immediately if any change in skin condition has occurred. The Charge Nurse follows up on any changes as reported with assessment of the Resident, notification to MD for | |

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| N 688 | Continued From page 94<br><br>documented as presenting as a Stage 3, measuring 3 cm by 5 cm, with a depth of 0.2 cm, with dark wound bed, normal skin surrounding the area and small amount of serosanguineous [bloody] exudate [drainage].<br><br>Medical record review of a Physician's Telephone order dated 1/6/16 revealed a new order for wound care to the left lateral heel "...cleanse Stage 3 [presenting] PU [pressure ulcer] to L lateral heel with wc/ns. Apply TAO [triple antibiotic ointment], cal alg [calcium alginate] and dry dsg daily et prn..."<br><br>Medical record review of the TAR for January 2016 revealed wound care was not completed on the resident's left lateral heel on 1/8/16, 1/9/16, 1/10/16, and 1/11/16.<br><br>Observation of the resident on 1/12/16 at 10:45 AM, in the resident's room, with the Wound Care Nurse, revealed the resident's wounds had not worsened since the wound care nurse's last assessment on 1/6/16.<br><br>Interview with the Wound Care Nurse on 1/12/16 at 1:06 PM, at the main nurse's station, revealed the Wound Care Nurse was scheduled to be in the facility on Wednesdays and Thursdays each week. Continued interview revealed when the Wound Care Nurse assessed the resident's wounds on 1/12/16 the dressing on the wound on the left heel was not dated and the wound care nurse was unsure the last time wound care was completed on this wound. Further interview revealed there was not a dressing in place on the right heel wound. Continued interview revealed the resident had a shower earlier in the day, the sacral wound dressing had fallen off, and she was unsure of when the last time the wound care | N 688 | treatment as needed, and documentation. The Assistant Director of Nursing collects the Skin Check monitoring forms to clinical meeting Monday-Friday for review and follow- up as needed with any change in condition for all residents.<br><br>All physician orders are brought to clinical meeting by the Director of Nursing Monday-Friday for review and to ensure all treatment orders received have been placed on the TAR by the nurse taking the order.<br><br>The clinical team will check the TAR daily against the physician's orders. Any holes in TARS will be investigated to determine if treatment was missed. Any nurse who is found to have treatments that are not done will have corrective action taken by the Assistant Director of Nursing/Director of Nursing/ Administrator.<br><br>4. Corporate nurse will be in facility weekly x 4 weeks then | |

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| N 688 | Continued From page 95<br><br>had been completed. Further interview revealed, "...sometimes [the wound care] may have been done, but sometimes the dressing in place still has my initials on it [from the week prior]..." Continued interview confirmed the wound to the resident's left lateral heel was a facility acquired pressure ulcer.<br><br>Interview with the Director of Nursing (DON) on 1/12/16 at 2:23 PM, in the Administrator's office, revealed the nurses scheduled on the 6 AM to 2 PM shift were responsible for completing wound care on the days the Wound Care Nurse was not in the building. Continued interview confirmed the Wound Care Nurse was scheduled in the facility on Wednesday and Thursdays only. Further interview confirmed the resident's wound care was not being completed as ordered.<br><br>Interview with the facility's Medical Director on 1/13/16 at 12:10 PM, in the Administrator's office, revealed the Medical Director was unaware wound care orders were not being completed as ordered. Continued interview and review of the TAR for Resident #76 confirmed if wound care was not being completed as ordered, any resident with a pressure ulcer would be at risk of development of a new pressure ulcer, worsening of a pressure ulcer, and placed residents with pressure ulcers at risk of harm.<br><br>Interview with Licensed Practical Nurse (LPN) #2 on 1/14/16 at 9:21 AM, at the main nurse's station, confirmed the LPN was scheduled to work in the facility Monday through Friday from 6 AM to 2 PM. Continued interview confirmed the LPN was assigned to care for Resident #76. Further interview confirmed the LPN was responsible for completing wound care on the assigned residents on the days the Wound Care | N 688 | monthly x 3 months.<br><br>All measures will be reviewed during QA meeting monthly x 3 months then quarterly x 1 year.<br><br>The QA Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, MDS Coordinator, Business Office Manager, Dietary Manager, Housekeeping Supervisor, Maintenance Director, Therapy Manager and Medical Director. | |

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| N 688 | Continued From page 96<br><br>Nurse was not scheduled. Continued interview and review of the resident's TAR for January 2016 confirmed the LPN had completed wound care on the resident's sacral wound on two days (1/1/16 and 1/4/16), had completed wound care on the resident's right lateral heel on one 1 day (1/4/16) "...I thought I did it more than that..." Further interview confirmed if the LPN had not signed the TAR then the LPN had not completed the wound care as ordered.<br><br>Interview with LPN #5 on 1/14/16 at 2:44 PM, at the main nurse's station, confirmed the LPN had been assigned to the resident on the 2 PM to 10 PM shift. Continued interview with the LPN confirmed the LPN had not completed any wound care for the resident.<br><br>Resident #24 was admitted to the facility on 8/20/10 with diagnoses including Alcoholic Cirrhosis of the Liver, Chronic Airway Obstruction, Dementia with Behavioral Disturbance, Depressive Disorder, Diabetes Mellitus, and Chronic Persistence Hepatitis and was readmitted to the facility on 7/10/15 with diagnoses of Aftercare for Healing Traumatic Fracture of the Hip and Difficulty Walking.<br><br>Medical record review of the resident's care plan initiated 10/30/15 revealed, "...the resident has potential for impairment to skin integrity r/t [related to] fragile skin..." Continued review revealed, "...Interventions/Tasks...treatments as ordered..."<br><br>Medical record review of a Braden Scale for Predicting Pressure Sore Risk last updated 12/1/15 revealed the resident scored a 19 "...Mild risk: total score 15-18..." Continued review revealed the facility had not accurately calculated | N 688 | | |

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| N 668 | Continued From page 97 | N 668 | | |

the wound risk score. Further review revealed the facility, while doing the addition to calculate the risk score, calculated the score as 19. However, when reviewing the document, the numbers were not added correctly and the true score was 17, indicating the resident was at a very low risk of developing a pressure ulcer.

Medical record review of a Wound Care Nurse note dated 12/30/15 revealed, "...Weekly skin assessment done. 2 new SDTI to R lateral heel and to R lateral foot..."

Medical record review of a Physician Telephone order dated 12/31/15 revealed, "...1. Apply skin prep and dry padded drsg to R heel SDTI as protection. (change Mon, Wed, Friday)...2. Apply skin prep and dry padded drsg to R lateral foot SDTI as protection (change Mon, Wed, Friday)..."

Medical record review of the TAR for January 2016 revealed the only days the resident's wound care was completed was on 1/6/16, 1/7/16, 1/12/16 and 1/13/16 (Wednesdays and Thursdays, the day the Wound Care Nurse was in the facility).

Medical record review of a Weekly Pressure Ulcer Record dated 1/12/15 for the resident's right lateral foot revealed the wound was documented as a SDTI measuring 0.8 cm by 0.8 cm, no depth, with a dark purple wound bed and normal skin surrounding the wound. Continued review revealed the wound was not draining and had dry, normal, and defined wound edges.

Medical record review of a Weekly Pressure Ulcer Record dated 1/12/15 for the resident's right lateral heel wound revealed the wound was documented as a SDTI measuring 1 cm by 1.5

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| N 668 | Continued From page 98<br><br>cm, with undetermined depth, and dark purple wound bed with normal skin surrounding the wound. Continued review revealed the wound was not draining and had defined wound edges.<br><br>Observation of the resident on 1/11/16 at 4:30 PM, in the hallway, revealed the resident up in a wheelchair self-propelling through the hallway. Continued observation revealed the resident was wearing shoes and socks.<br><br>Observation of the resident on 1/12/16 at 8:35 AM, in the front lobby, revealed the resident up in a wheelchair self-propelling through the hallway. Continued review revealed the resident was wearing shoes and socks.<br><br>Interview with LPN #1 on 1/15/16, at 9:44 AM, at the main nurse's station confirmed the LPN was assigned to care for the resident Monday through Friday from 6 AM to 2 PM. Continued interview confirmed the LPN was aware she was responsible for completing wound care for the resident on the days the Wound Care Nurse was not scheduled to be in the facility. Further interview revealed the LPN had not been made aware of the development of the SDTI on the resident's right heel and right foot. Further interview confirmed the LPN had not completed any wound care for the resident since the initiation of the physician's order on 12/31/15.<br><br>Resident #77 was admitted to the facility on 1/6/16 with diagnoses including Complete Traumatic Amputation between Knee and Ankle, End Stage Renal Disease, Complete Traumatic Amputation of Left Great Toe, Perforation of Intestine, Peripheral Vascular Disease, Gangrene, Diabetes Mellitus, Pressure Ulcer of Sacral Region Stage 2, Pressure Ulcer of Left | N 668 | | |

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| N 668 | Continued From page 99<br>Heel Unstageable, and Colostomy.<br><br>Medical record review of the hospital discharge wound care orders dated 12/31/15 revealed, "...To left great toe amputation site, L heel, and R BKA [below knee amputation] incision: 1. Cleanse with wound cleanser and pat dry 2. Paint with betadine DAILY- leave open to air..."<br><br>Medical record review of a Resident Data Collection Admission Assessment dated 1/5/16 revealed, "...Skin Condition...1. Amputation of RBK [right below knee]...L heel necrotic, amp [amputation] of left great toe..."<br><br>Medical record review of the TAR for January 2016 revealed the following treatment orders: "...To L great toe: cleanse with wound cleanser pat dry, paint with betadine daily...leave open to air or wrap for comfort/drainage...To L heel: cleanse with wound cleanser, pat dry, paint with betadine daily, leave open to air/or wrap for comfort/drainage..." Continued review of the TAR for January 2016 revealed the wound care ordered for the resident's left great toe and left heel were completed the days the Wound Care Nurse was scheduled to work on 1/6/16 and 1/7/16.<br><br>Medical record review of a Wound Care Nurse note dated 1/6/16 revealed, "...Resident has L great toe amputation with black necrotic tissue to surgical site and discoloration is growing and also developing to 2nd toe...Also unstageable PU [pressure ulcer] to L heel..."<br><br>Medical record review of a Physician Telephone order dated 1/6/16 revealed a new treatment order for the resident's 2nd toe "...betadine to 2nd toe L foot daily..." | N 668 | | |

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| N 688 | Continued From page 100<br><br>Medical record review of the TAR for January 2016 revealed the wound treatment orders were only completed on the days the wound care nurse was in the building (1/6/16 and 1/7/16) and was not completed on 1/8/16 through 1/11/16 (a total of 4 days).<br><br>Medical record review of Wound/Skin Record dated 1/13/16 revealed the wound on the left great toe measured 10 cm by 10 cm with an undetermined depth, necrotic wound bed with darkening onto the surrounding skin of the plantar foot. Continued review revealed the wound was assessed as "...no change..." from previous assessment on 1/5/15. Continued review revealed the pressure wound (SDTI) on the left heel was documented as measuring 3 cm by 5 cm, unstageable, with undetermined depth. Continued review revealed the wound bed was "...black-necrotic..." with the surrounding skin normal and pink with defined wound edges. Further review revealed the wound was documented as unchanged from the previous assessment on 1/6/16.<br><br>Interview with the facility's Medical Director on 1/13/16 at 12:10 PM, in the Administrator's office, confirmed the Medical Director was unaware the resident's wounds were not being treated as ordered. Continued interview with the Medical Director confirmed the facility's failure to treat pressure wounds as ordered could result in the worsening or development of new pressure wounds and placed residents at risk for further harm.<br><br>Interview with the Wound Care Nurse on 1/14/16 at 9:30 AM, at the main nurse's station, revealed when the Wound Care Nurse came to the facility | N 688 | | |

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| N 688 | Continued From page 101<br><br>on 1/11/16 and assessed Resident #24's wounds to the left great toe and left heel, the bandages which were present were still dated for the last day the Wound Care Nurse was scheduled to work, 1/7/16.<br><br>Interview with LPN #2 on 1/14/16 at 9:21 AM, at the main nurse's station, confirmed the LPN was assigned to care for the resident Monday through Friday from 6 AM to 2 PM. Continued interview confirmed the LPN had only completed wound care on the resident's right below knee amputation due to the amount of drainage from the wound. Continued interview confirmed the LPN did not complete any wound care to the resident's left great toe or left heel.<br><br>Interview with the DON on 1/15/16 at 9:32 AM, in the Administrator's office, revealed the Wound Care Nurse was only in the facility on Wednesdays and Thursdays. Continued interview revealed the LPNs scheduled to work the 6 AM to 2 PM shift were responsible for completing wound care for their assigned residents on the days the Wound Care Nurse was not scheduled. Further interview revealed the LPNs were responsible for checking the TARs on these days to ensure all wound care orders were being followed. Continued interview confirmed wound care orders for the three residents with pressure ulcers were not being completed as ordered.<br><br>Summary: Review of medical records and interviews with staff conducted during the survey revealed no systematic process was in place to ensure treatment orders for wounds were being completed as ordered on days the Wound Care Nurse was not in the facility, which was only two days a week (Wednesday and Thursday). | N 688 | | |

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| N 686 | Continued From page 102<br>Interviews conducted with the Director of Nursing and the Medical Director revealed neither were aware treatment orders were not completed on the days the Wound Care Nurse was not scheduled in the facility. Interviews revealed neither the Director of Nursing or the Medical Director had investigated whether the development of the SDTIs for Resident #76 or Resident #24 were preventable or unavoidable. | N 686 | | |